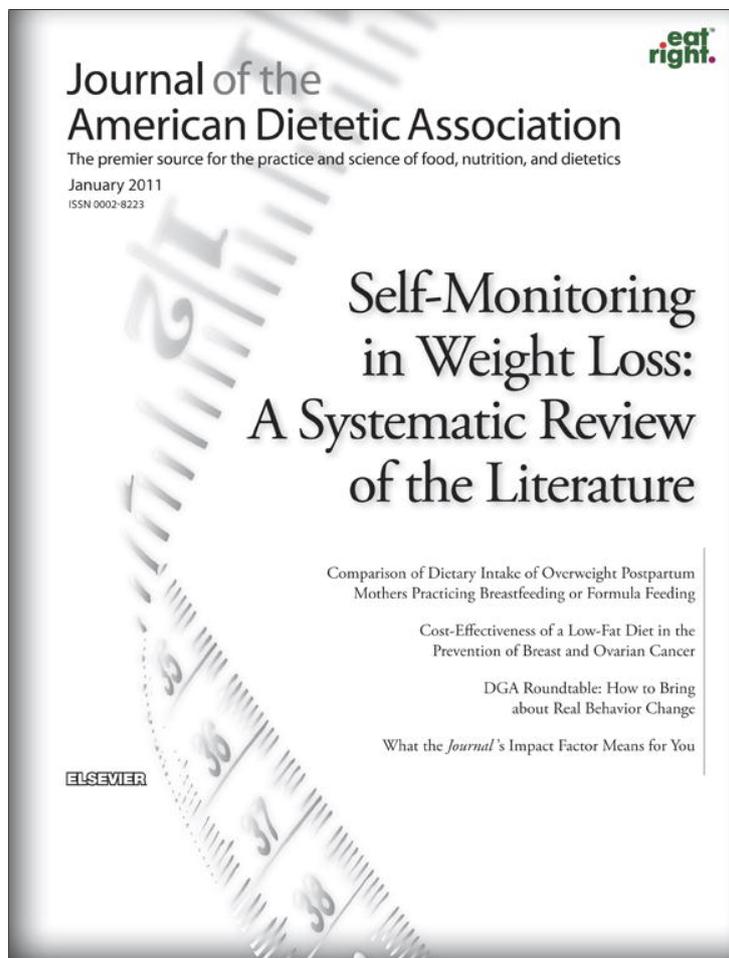


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from the association

American Dietetic Association Revised Standards of Practice and Standards of Professional Performance for Registered Dietitians (Generalist, Specialty, and Advanced) in Diabetes Care

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Approved September 2010 by the Quality Management Committee of the American Dietetic Association House of Delegates and the Executive Committee of the Diabetes Care and Education Dietetic Practice Group of the American Dietetic Association. **Scheduled review date:** January 2016. Questions regarding the revised Standards of Practice and Standards of Professional Performance for registered dietitians in diabetes care may be addressed to ADA Quality Management staff at quality@eatright.org; Sharon McCauley, MS, MBA, RD, LDN, FADA, director of Quality Management, or Cecily Byrne, MS, RD, LDN, manager of Quality Management.

Editor's note: Figures 1, 2, and 3 that accompany this article are available online at www.adajournal.org.

The Diabetes Care and Education Dietetic Practice Group (DCE DPG) of the American Dietetic Association (ADA), under the guidance of the ADA Quality Management Committee and Scope of Dietetics Practice Framework Sub-Committee, has revised the Standards of Practice (SOP) and Standards of Professional Performance (SOPP) for registered dietitians (RDs) in diabetes care (see the Web site exclusive **Figures 1, 2, and 3** at www.adajournal.org). The SOP and SOPP for RDs in diabetes care were originally published in

2005 (1) and were scheduled for periodic review and revision. The revised documents reflect advances in diabetes nutrition practice during the past 5 years and replace the 2005 standards. These documents build on the ADA revised 2008 SOP for RDs in nutrition care and SOPP for RDs (2). The SOP in nutrition care address the four steps of the Nutrition Care Process and activities related to patient/client care (3). They are designed to promote the provision of safe, effective, and efficient food and nutrition services, facilitate evidence-based practice, and serve as a professional evaluation resource. The SOPP are authoritative statements that describe a competent level of behavior in the professional role. Categorized behaviors that correlate with professional performance are divided into six separate standards.

ADA's Code of Ethics (4) and the revised 2008 SOP in nutrition care and SOPP for RDs (2) are decision tools within the Scope of Dietetics Practice Framework (5) that guides the practice and performance of RDs in all settings. The concept of scope of practice is fluid (6), changing in response to the expansion of knowledge, the health care environment, and technology. An RD's legal scope of practice is defined by state legislation (eg, state licensure law) and will differ from state to state. An RD may determine his or her own individual scope of practice using the Scope of Dietetics Practice Framework (5), which takes into account federal regulations; state laws; institutional pol-

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In October and November 2010, the House Leadership Team of the American Dietetic Association House of Delegates approved the Council on Future Practice's Dietetics Career Development Guide, as well as definitions for focus area of dietetics practice, specialist, and advanced practice, respectively. The Dietetics Career Development Guide is based on the Dreyfus Model of Skill Acquisition* which suggests that as a person acquires and develops a skill, s/he "... usually passes through at least five stages of qualitatively different perceptions of his task and/or mode of decision-making as his skill improves." The stages are: novice, advanced beginner, competent, proficient, and expert.

At the competent stage, a dietetics practitioner has just obtained the RD or DTR credential, starting in an employment situation, and gains on the job skills as well as tailored continuing education to enhance skills and knowledge. The RD or DTR as a beginner starts the technical training and interaction for advancement and breadth of competence. At the proficient stage, the RD or DTR is three plus years beyond entry into the profession, has obtained operational job performance skills and is successful in the chosen focus area of practice. The RD or DTR may begin to acquire specialist credentials, if available, to demonstrate proficiency in a focus area of practice. At the expert stage, the RD or DTR is recognized within the profession and has mastered the highest degree of skill in or knowledge of a certain focus or generalized area of dietetics through additional knowledge, experience, or training.

The Council on Future Practice has recommended with approval by the Quality Management Committee and Scope of Dietetics Practice Framework Sub-committee that all future practice-specific Standards of Practice (SOP) and Standards of Professional Performance (SOPP) use the terms *competent*, *proficient*, and *expert* to describe the levels of dietetics practice, versus the terminology generalist, specialty, and advanced. In addition, these documents will be referred to as *focus area SOP and SOPP*.

At press time, the *Revised SOP and SOPP for RDs in Diabetes Care* contains the verbiage generalist, specialty, and advanced to describe the levels of dietetics practice. Because the *Revised SOP and SOPP for RDs in Diabetes Care* was approved for publication in September 2010, it was not feasible to incorporate the changes in terminology. In future focus area SOP and SOPP publications, the levels of practice will be referred to as competent, proficient, and expert.

For questions on the Dietetics Career Development Guide or its terminology, please visit www.eatright.org/futurepractice.

*Dreyfus HL, Dreyfus SE. *Mind Over Machine*. New York, NY: The Free Press; 1986.

icies and procedures; and individual competence, accountability, and responsibility for his or her own actions.

ADA's revised 2008 SOP in nutrition care and SOPP (2) reflect the minimum competent level of dietetics practice and professional performance for RDs. ADA's SOP in nutrition care and SOPP serve as blueprints for the development of practice-specific SOP and SOPP for RDs in generalist, specialty, and advanced levels of practice.

The standards are a guide for self-evaluation and expanding practice, a means of identifying areas for professional development, and a tool for demonstrating competence in delivering diabetes care and education. They are used by RDs to assess their current level of practice and to determine the education and training required to maintain currency in their practice area and advancement to a higher level of practice. In addition, the standards may be used to assist RDs in transitioning their knowledge and skills to a new practice area. Like the revised 2008 SOP in nutrition care and SOPP for RDs, the revised SOP

and SOPP for RDs in diabetes care were developed with input and consensus of content experts representing diverse practice and geographic perspectives and were reviewed and approved by the Executive Committee of the DCE DPG, the Scope of Dietetics Practice Framework Sub-Committee, and ADA's Quality Management Committee.

Three levels of practice in diabetes care—generalist, specialty, and advanced—are defined (7). A general practitioner (or generalist) is an individual whose practice includes responsibilities across several areas of practice, including, but not limited to, more than one of the following: community, clinical, consultation and business, research, education, and food and nutrition management. The generalist level also includes entry-level practitioners. An entry-level practitioner, as defined by the Commission on Dietetic Registration, has <3 years of registered practice experience and demonstrates a competent level of dietetics practice and professional performance. A specialty practitioner is an individual who primar-

ily concentrates on one aspect of the profession of dietetics. This specialty may or may not have a credential and additional certification, but often includes expanded roles beyond entry level practice. An advanced practitioner has acquired the expert knowledge base, complex decision-making skills, and competencies for expanded practice, the characteristics of which are shaped by the context in which he or she practices. Advanced practitioners may have expanded or specialty roles or both. Advanced practice may or may not include additional certification. Generally the practice is more complex, and the practitioner has a higher degree of professional autonomy and responsibility.

These standards, along with ADA's Code of Ethics (4), answer the questions: "What uniquely qualifies an RD to provide diabetes nutrition services?" and, "What knowledge, skills, and competencies does an RD need to demonstrate for the provision of safe, effective, and quality diabetes care at the generalist, specialty, and advanced levels?"

OVERVIEW

Diabetes is a significant health challenge. In 2007 in the United States, estimates suggested that nearly 24 million individuals had diabetes and another 57 million were at increased clinical risk of developing this chronic disease (ie, prediabetes) (8). Diabetes has consistently been among the top causes of morbidity and mortality among patients with chronic disease, and the costs associated with diabetes care place a significant financial burden on the country's health care system. It is well-documented that keeping blood glucose and blood pressure at near-normal levels significantly reduces diabetes complications (9,10). Yet despite this widely known information, the National Health and Nutrition Examination Survey data have observed that the age-adjusted percentage of people achieving glycemic, blood pressure, and cholesterol targets (ie, all three targets) increased only from 7.0% in the period 1999-2002 to 12.2% in the period between 2003 and 2006 (11). Although the proportion of those achieving these three targets appears to be increasing, there remains a significant proportion of individuals with diabetes who fail to achieve recommended hemoglobin A1c (HbA1c), blood pressure, and cholesterol levels.

Given the rapid rise of diabetes over the past several decades and the immense opportunity to improve diabetes-related measures, the need for RDs with diabetes expertise is critical to improve the health of individuals both at risk for diabetes and with diabetes. Nutrition has been recognized as one of the three cornerstones of diabetes management, along with medication therapy and exercise. Studies implementing a variety of nutrition interventions report a reduction in HbA1c levels (12-15). Strong evidence suggests that the quantity as well as the type of carbohydrate determine the postprandial blood glucose levels (12,13). In addition, some studies also report improvements in lipid profiles, improved weight management, adjustments in medications, and a reduction in the risk for onset and progression of comorbidities with nutrition intervention (14). Diabetes medical nutrition therapy (MNT) provided by RDs can effectively decrease HbA1c by approximately 1% to 2% (range -0.5% to -2.6%), depending on

the type and duration of diabetes (14,15). MNT has the greatest effect following the initial diagnosis and continues to be effective throughout the disease process. Outcomes of nutrition interventions are generally measurable in 6 weeks to 3 months and evaluations by an HbA1c test should be done at this time. If a patient's/client's glycemic control has not clinically improved at 3 months, the RD should contact the referral source and recommend the need for initiation or a change in diabetes medication.

Nutrition therapy provided by an RD can also help individuals prevent or delay the development of diabetes. Intensive lifestyle changes (ie, at least 150 minutes/week of physical activity and reduced energy intake) and weight loss (ie, 7% of initial body weight) have been demonstrated to reduce diabetes risk (16). In the first 2.8 years of the Diabetes Prevention Program (DPP) (16), diabetes incidence in high-risk adults was reduced by 58% as a result of these intensive lifestyle interventions and 31% by metformin only compared with placebo. Ten years later at follow-up, the DPP participants who had received the original intensive lifestyle intervention had maintained their lower rate of diabetes onset (17).

RDs providing diabetes care recognize that effectively addressing the challenges of managing and preventing diabetes requires specialized knowledge and skills. The Diabetes Control and Complications Trial (DCCT) documented the expanded role of RDs in the care of type 1 diabetes; the DCCT established RDs as more active team participants focused not only on nutrition, but on assisting with medication therapy, weight management, and exercise strategies to improve glycemic control (18,19). The United Kingdom Prospective Diabetes Study documented the role of dietitians as research interventionists and demonstrated the influence of diet in the treatment of type 2 diabetes (20-22). The DPP documented the expanded RD role in preventing type 2 diabetes. RDs served as case managers, and in some centers, the RDs served as program coordinators and participated on national study committees (23). In both the DCCT and DPP, RDs designed and conducted ancillary substudies and participated in writing groups for the primary results articles. Beyond these large trials, the RD role has also expanded to include

teaching self-management skills that include proper administration of injectable medications, self-blood glucose monitoring, insulin pump therapy, and teaching individuals how to treat hypoglycemia and hyperglycemia (24). In some clinical settings an RD's role has evolved to include a role in managing dyslipidemia and blood pressure through use of stepwise protocols to initiate and titrate medications (25-27).

RDs in diabetes care work as members of multidisciplinary health care teams in a variety of work environments (eg, clinics, education centers, hospitals, community health settings, health plans, industry, or private practice). Nutrition education and counseling are integral components of high quality diabetes care. MNT pertains to clinical management and, as such, is conducted by RDs. The differences between the provision of nutrition education and counseling in diabetes care were defined and described in a Diabetes White Paper (28). Diabetes self-management training and community programs include nutrition education (ie, instructional methods) that promote healthful behaviors by imparting information that individuals and groups can use to make informed decisions about food, eating habits, and health (28). MNT "is an evidence-based application of the Nutrition Care Process focused on prevention, delay or management of diseases and conditions, and involves an in-depth assessment, periodic re-assessment and intervention." (7) MNT services are defined in Medicare statutes as "nutritional diagnostic, therapy, and counseling services for the purpose of disease management which are furnished by an RD" (29). (Medicare MNT Benefit).

ADA REVISED STANDARDS OF PRACTICE AND STANDARDS OF PROFESSIONAL PERFORMANCE FOR RDs (GENERALIST, SPECIALTY, AND ADVANCED) IN DIABETES CARE

An RD may use the Revised SOP and SOPP (generalist, specialty, and advanced) for RDs in diabetes care (see the Web site exclusive Figures 1, 2, and 3 at www.adajournal.org) to:

- identify the competencies needed to provide diabetes care inclusive of diabetes self-management training and MNT;

How to Use the Revised Standards of Practice and Standards of Professional Performance for Registered Dietitians (Generalist, Specialty, and Advanced) in Diabetes Care as part of the Professional Development Portfolio Process^a

1. Reflect	Assess your current level of practice and whether your goals are to expand your practice or maintain your current level of practice. Review the Standards of Practice and Standards of Professional Performance document to determine what you want your future practice to be, and assess your strengths and areas for improvement. These documents can help you set short- and long-term professional goals.
2. Conduct learning needs assessment	Once you have identified your future practice goals, you can review the Standards of Practice and Standards of Professional Performance document to assess your current knowledge, skills, behaviors, and define what continuing professional education is required to achieve the desired level of practice.
3. Develop learning plan	Based on your review of the Standards of Practice and Standards of Professional Performance, you can develop a plan to address your learning needs as they relate to your desired level of practice.
4. Implement learning plan	As you implement your learning plan, keep reviewing the Standards of Practice and Standards of Professional Performance document to re-assess knowledge, skills, and behaviors and your desired level of practice.
5. Evaluate learning plan process	Once you achieve your goals and reach or maintain your desired level of practice, it is important to continue to review the Standards of Practice and Standards of Professional Performance document to re-assess knowledge, skills, and behaviors and your desired level of practice.

Figure 4. Application of the Commission on Dietetic Registration *Professional Development Portfolio* Process.^aThe Commission on Dietetic Registration *Professional Development Portfolio* process is divided into five interdependent steps that build sequentially upon the previous step during each 5-year recertification cycle and succeeding cycles.

- self-assess whether he or she has the appropriate knowledge base and skills to provide safe and effective diabetes care for their individual level of practice;
- identify the areas in which additional knowledge and skills are needed to perform at the generalist, specialty, or advanced level of diabetes care practice;
- provide a foundation for public and professional accountability in diabetes care;
- assist management in the planning of diabetes care services and resources;
- enhance professional identity and communicate the nature of diabetes care;
- guide the development of diabetes care-related education and continuing education programs, job descriptions, and career pathways; and
- assist preceptors in teaching students and interns the knowledge, skills, and competencies needed to work in diabetes care and the understanding of the full scope of this profession.

This approach to professional standards allows for recognition of the independent provider status for RDs resulting from the Medicare MNT statute that became effective January 1, 2001. Independent provider status recognizes the RD credential as indicating that an individual is qualified to pro-

vide and be reimbursed directly for MNT services (30,31). The standards are also reflective of the knowledge and skills required for additional certifications. Current certifications available to an RD in diabetes care are certified diabetes educator (CDE), a specialty certification, and the Board certified-advanced diabetes management (BC-ADM), an advanced practice certification. RDs with the demonstrated level of competence (ie, who meet the revised Standards of Practice and Standards of Professional Performance for RDs in diabetes care), along with the appropriate hours of practice and who meet any additional requirement of the credentialing boards for the CDE or the BC-ADM certifications, can also choose to obtain the CDE or BC-ADM credentials. More information on obtaining the CDE credential is available from the National Certification Board for Diabetes Educators (www.ncbde.org) (32-34) whereas information on the BC-ADM credential (33,34) is available from the American Association of Diabetes Educators (www.diabeteseducator.org).

APPLICATION TO PRACTICE

The Dreyfus model (35) identifies levels of proficiency (novice, proficiency, expert) during the acquisition and development of knowledge and skills. This model is helpful in understanding the levels of practice described in

the revised SOP and SOPP for RDs in diabetes care. In the ADA practice-specific SOP and SOPP for RDs, the stages are represented as generalist, specialty, and advanced practice levels.

All RDs, even those with significant experience in other practice areas, begin at the novice level (generalist level) when practicing in a new setting. At the novice level (generalist level), an RD in diabetes care is learning the principles that underpin the practice and is developing skills for effective diabetes care. This RD, who may be an experienced RD or may be new to the profession, has a breadth of knowledge in nutrition overall and may have specialty or advanced knowledge/practice in another area. However, an RD new to the specialty of diabetes care may experience a steep learning curve.

At the proficiency stage (specialty level), an RD has developed a deeper understanding of diabetes care and is better equipped to apply evidence-based guidelines and best practices. This RD is also able to modify practice according to unique situations (eg, an RD assesses blood glucose monitoring results and needs for MNT and medication adjustments, calculates insulin-to-carbohydrate ratios and insulin sensitivity factors, and assesses other metabolic outcomes).

At the expert stage (advanced practice level), an RD thinks critically about

Role	Generalist	Specialty	Advanced
<p>Clinical practitioner</p>	<p>An RD in general clinical practice is a Medicare medical nutrition therapy (MNT) provider for patients/clients with diabetes, and works part-time in private practice and part-time at a diabetes outpatient clinic. The RD reviews the Nutrition Practice Guidelines for type 1 and type 2 diabetes mellitus for each aspect of the nutrition care process. The RD then reviews the <i>Revised SOP and SOPP for RDs in Diabetes Care</i> to evaluate his or her own skills and competencies for providing care to individuals with diabetes and sets goals to improve competency in this area of practice.</p>	<p>The RD has determined that many of the patients/clients referred for MNT would benefit from instruction on how their food choices impact their glycemic control. The RD wants to instruct patients in the private practice/clinic on how to self-monitor blood glucose (SMBG). The RD reviews the <i>Revised SOP and SOPP for RDs in Diabetes Care</i> to evaluate his or her knowledge, skills and competencies for providing instruction on SMBG.</p> <p>The RD learns how to teach SMBG from an advanced practice RD. Review of the <i>Revised SOP for RDs in Diabetes Care</i> reveals that the RD needs to develop skills and competencies in the areas of hypoglycemia recognition and treatment, blood glucose targets, sharp's disposal, and blood borne pathogens. The RD investigates his or her institution's policies and procedures, and local and state policies, procedures, and regulations for performing invasive procedures of this kind. Education, training, and competency to teach these diabetes self-care tasks/skills/topics are documented.</p>	<p>The RD in advanced practice has mastered how to provide instruction on SMBG and is able to teach how food and medication impact glycemic control. The RD has also successfully completed certification to instruct patient/client on use of an insulin pump. The RD has determined that some of his or her patients/clients would benefit from use of a continuous glucose monitoring (CGM) device system to monitor glucose in an effort to better optimize glycemic control. In addition, the RD wants to learn how to interpret pump and CGM device system download data reports to make carbohydrate and insulin dose adjustment recommendations. The RD reviews the <i>Revised SOP and SOPP for RDs in Diabetes Care</i> to evaluate his or her knowledge, skills and competencies for providing instruction on use of a CGM device system. The RD also investigates his or her institution's policies and procedures, and local and state policies, procedures, and regulations for performing related invasive procedures, such as insertion of a glucose sensor. Education, training, and competency to instruct patient/client on use of CGM device systems are documented.</p>
<p>Manager</p>	<p>A nutrition services manager of a large hospital oversees a number of RDs providing MNT to individuals with a variety of medical conditions, including diabetes. The manager will consider the <i>Revised SOP and SOPP for RDs in Diabetes Care</i> when determining work assignments, expertise needed at the program level, and when assisting staff in evaluating competency and individual needs for additional knowledge and/or skills in MNT for diabetes. The manager recognizes the SOP and SOPP as important tools for staff to use to assess their own competencies and to use as the basis for identifying personal performance plans.</p>	<p>A specialty practice RD who is also a certified diabetes educator (CDE) requests an appointment with his or her department manager to discuss departmental approval for providing instruction on insulin syringe and insulin pen administration. The manager reviews the <i>Revised SOP and SOPP for RDs in Diabetes Care</i> available on the ADA Web site (www.eatright.org) to determine whether insulin administration is in the RD SOP. The manager assists the practitioner in investigating institutional policies, procedures, guidelines, and state licensure regulations. Based on the SOP, the manager develops a set of competencies that need to be achieved by the RD/CDE in order to provide instruction on insulin administration. Education, training, and competency to teach insulin administration is documented. The manager also includes this task/skill in the job description for the RD.</p>	<p>There is a vacancy at a diabetes education center for the clinical services department manager. The manager oversees a number of specialty and advanced practice diabetes educators, including RDs. The position has historically been filled by an advanced practice registered nurse (RN) who also holds the Board Certified-Advanced Diabetes Management (BC-ADM) credential. One of the current staff RD/CDEs applies for the position. The RD/CDE uses the <i>Revised SOP and SOPP for RDs in Diabetes Care</i> to prepare for his or her interview. Using the <i>Revised SOP and SOPP for RDs in Diabetes Care</i> as a guide, the RD/CDE compiles a set of competencies that he or she currently performs at the advanced practice level. The RD/CDE shares this information during the interview with the director making the hiring decision and they discuss any additional competencies the RD/CDE needs to achieve to meet the job requirements.</p> <p style="text-align: right;"><i>(continued)</i></p>

Figure 5. Case Examples of how the registered dietitian (RD) utilizes the *Revised Standards of Practice (SOP) and Standards of Professional Performance (SOPP)* for Registered Dietitians (RDs) (*Generalist, Specialty, and Advanced*) in *Diabetes Care* to assess competencies and set goals as part of the professional development portfolio plan.

Role	Generalist	Specialty	Advanced
Public health practitioner	<p>An RD employed at a county health department wants to provide diabetes prevention classes to individuals identified with pre-diabetes through a community screening. The RD reviews the Diabetes Prevention Program curriculum available online. (http://www.bsc.gwu.edu/dpp/manuals.html#doc) The RD develops a diabetes prevention program for the county health department. The RD then reviews the <i>Revised SOP and SOPP for RDs in Diabetes Care</i> to evaluate his or her own knowledge, skills, and competencies for providing instruction to class participants with pre-diabetes.</p>	<p>An RD teaching diabetes prevention classes working with this population and wants to advance his or her level of practice. The RD reviews nutrition assessment and intervention sections of the <i>Revised SOP and SOPP for RDs in Diabetes Care</i> to determine necessary knowledge, skills, and demonstrated competencies to advance to specialty practice and sets applicable goals, including a goal to successfully attain the CDE credential.</p>	<p>The state diabetes prevention and control program manager is an advanced practice RD. This RD has a graduate degree in public health and holds the CDE credential. This individual oversees grant funding for several diabetes initiatives in the state. The program manager wants to conduct continued research on the outcomes of one of the state's diabetes initiatives. The RD reviews the <i>Revised SOP and SOPP for RDs in Diabetes Care</i> to develop his or her Professional Development Portfolio with the goal of advancing his or her practice. He or she includes in his or her plan the goals of being a principal investigator for the research study, designing the study, publishing an article in a peer-reviewed journal, and presenting the results at a national diabetes and/or public health-related meeting.</p>
Nontraditional health care practitioner	<p>An RD takes a position as a telephone coach for a health management company working with large employers across the country. As part of the position, the telephone coach will be coaching individuals at risk for diabetes or with active disease. The RD reviews the <i>Revised SOP and SOPP for RDs in Diabetes Care</i> to determine the knowledge, skills and competencies he or she will need to assess, identify and coach individuals with prediabetes or diabetes. The RD develops a plan for education and skill development and incorporates into his or her Professional Development Portfolio.</p>	<p>A specialty practice RD/CDE who has been providing telephone coaching for individuals with diabetes for several years sees an opening in the case management department for a case manager to focus on individuals with diabetes and/or heart disease. The RD/CDE would like to more fully utilize his or her specialty level knowledge, skills, and competencies through working more in-depth with patients/clients. The RD/CDE reviews the job description and determines that he or she has the assessment/intervention skills applicable to the job and applies for the position. The RD/CDE reviews the <i>Revised SOP and SOPP for RDs in Diabetes Care</i> to prepare for the interview to make sure he or she can demonstrate to the hiring director that he or she has the knowledge, skills and competencies required for the position, which has traditionally been held by RNs. Through the <i>Revised SOP and SOPP for RDs in Diabetes Care</i>, the RD/CDE is able to demonstrate that he or she is qualified for the position and provides evidence of applying the necessary knowledge, skills, and competency in practice situations. The RD/CDE is hired and works to create a professional development plan that allows for continued practice at the specialty level.</p>	<p>A health plan has Disease Management Certification for its diabetes management program through the National Committee for Quality Assurance (NCQA). The RD, who also holds the BC-ADM credential, uses the <i>Revised SOP and SOPP for RDs in Diabetes Care</i> to assess knowledge, skills, and competencies required for creation of evaluation tools, outcomes systems and collecting and reporting data as part of a quality improvement process to improve diabetes outcomes and quality of care. The advanced practice RD sets goals to advance knowledge or skills as needed.</p>

(continued)

Figure 5. (Continued)

Role	Generalist	Specialty	Advanced
Researcher	An RD takes a new position working for a research study that will compare the benefits of intensive nutritional counseling for diabetes and cardiovascular disease vs a traditional nutritional counseling schedule. The RD will see intensive study participants on a monthly basis for 3 years while standard of care participants will be seen for an initial visit followed by two brief follow-up visits each year. The RD will review the <i>Revised SOP and SOPP for RDs in Diabetes Care</i> to assess his or her competencies and identify knowledge, skills, and competencies that may require growth and demonstrated ability for this new role. The RD sets goals to attain any needed competencies before working with study participants.	An RD is hired as a study coordinator for a multi-site research trial that will determine whether intensive blood pressure management, intensive blood glucose management, and decreased protein intake as opposed to standard-of-care treatment can delay progression of renal disease for people with diabetes. He or she screens individuals for appropriateness as study participants, conducts the informed consent process, and oversees the participant visits. The latter includes obtaining blood pressure measurements, instruction on use of study medications (including injectables), and recommended changes in treatment according to the study protocol and with MD approval. He or she reviews the <i>Revised SOP and SOPP for RDs in Diabetes Care</i> to ensure that his or her knowledge, skills, and competencies are consistent with the specialty level of practice and to determine knowledge, skills and competencies that may need to be updated.	After conducting a review of current literature, an advanced-practice RD submits a research proposal to a funding agency for a new research study where the RD will be the principal investigator. The clinical trial will seek to determine the effect of intensive nutritional counseling for polycystic ovary syndrome (PCOS) on participant outcomes during pregnancy. As part of his or her research, he or she consults with other health care professionals, and university departments (eg, research consulting unit or institutional review board). He/ She reviews the <i>Revised SOP and SOPP for RDs in Diabetes Care</i> for guidance as to areas of knowledge, skills, and competencies that may require growth and demonstrated ability for this new role.

Figure 5. (Continued)

diabetes care, demonstrates a more intuitive understanding of diabetes care and practice, displays a range of highly developed clinical and technical skills, and formulates judgments acquired through a combination of experience and education. Essentially, practice at the advanced level requires the application of composite dietetics knowledge, with practitioners drawing not only on their clinical experience, but also on the experience of diabetes practitioners in various disciplines and practice settings. Experts, with their extensive experience and ability to see the significance and meaning of diabetes care within a contextual whole, are fluid and flexible and, to some degree, autonomous in practice. They not only implement diabetes care, they also drive and direct clinical practice, conduct and collaborate in research, contribute to multidisciplinary teams, and lead the advancement of diabetes care.

Indicators for the revised SOP (Figure 2, available online at www.adajournal.org) and SOPP (Figure 3, available online at www.adajournal.org) for RDs in diabetes care are measurable action statements that illustrate how each standard may be applied in practice. Within the revised SOP and SOPP for RDs in diabetes care, an X in the generalist column indicates that an RD who is caring for patients/clients is expected to complete this activity and/or seek assistance to learn how to perform at the level of the standard. A generalist in diabetes care could be an entry-level RD or an experienced RD who has newly assumed responsibility to provide diabetes care to patients/clients. An X in the specialty column indicates that an RD who performs at this level has a deeper understanding of diabetes care and has the ability to modify therapy to meet the needs of patients/clients in various situations (eg, instruct patient/client how to self-monitor blood glucose in addition to the carbohydrate counting meal planning approach for the patient/client to determine how their food choices affect their glycemic control, and recommends medication adjustments, if needed). An X in the advanced column indicates an RD who performs at this level possesses a comprehensive understanding of diabetes care and a highly developed range of skills and judgments acquired through a combination of experience and education (eg, an RD who instructs patients referred

for MNT on use of an insulin pump to deliver mealtime insulin and on use of a continuous glucose monitor to monitor glucose in an effort to optimize glycemic control). An RD, drawing on experiential and advanced knowledge, uses downloaded insulin pump and continuous glucose monitor data to evaluate insulin-to-carbohydrate ratios and insulin sensitivity factors and make dose adjustment recommendations as indicated).

Bolded type standards and indicators originate from ADA's revised 2008 SOP in nutrition care and SOPP for RDs (2) and should apply to RDs in all three categories. Several indicators not in boldface type are identified as applicable to all levels of practice. Where Xs are placed in all three categories of practice, it is understood that all RDs in diabetes care are accountable for practice within each of these indicators. However, the depth with which an RD performs each activity will increase as the individual moves beyond the generalist level. Level of practice considerations warrant that a holistic view of the revised SOP and SOPP for RDs in diabetes care be taken. It is the totality of individual practice that defines the level of practice and not any one indicator or standard.

RDs should review the revised SOP and SOPP for RDs in diabetes care at regular intervals to evaluate individual nutrition and diabetes care knowledge, skill, and competence. Regular self-evaluation is important because it helps identify opportunities to improve and/or enhance practice and professional performance. This self-appraisal also enables RDs in diabetes care to better utilize the Commission on Dietetic Registration's *Professional Development Portfolio* (36) for self-assessment, planning, improvement, and commitment to lifelong learning. These Standards may be used in each of the five steps in the *Professional Developmental Portfolio* process (see Figure 4). RDs are encouraged to pursue additional training, regardless of practice setting, to maintain currency and to expand individual scope of practice within the limitations of the legal scope of practice, as defined by state law. Individuals are expected to practice only at the level at which they are competent, and this will vary depending on education, training, and experience (37). RDs are encouraged to pursue ad-

ditional diabetes knowledge, skills training, and competence regardless of practice setting to promote consistency in practice and performance and continuous quality improvement. See Figure 5 for case examples of how RDs in different roles and at different levels of practice may use the revised SOP and SOPP for RDs in diabetes care.

In some instances, components of the revised SOP and SOPP for RDs in diabetes care do not specifically differentiate between specialty and advanced level practice. In these areas, it was the consensus of the content experts that the distinctions are subtle, captured in the knowledge, experience, and intuition demonstrated in the context of practice at the advanced level, which combines dimensions of understanding, performance, and value as an integrated whole (38). A wealth of knowledge is embedded in the experience, discernment, and practice of advanced-level RD practitioners. The knowledge and skills acquired through practice will continually expand and mature. The indicators will be refined as advanced-level RDs systematically record and document their experience using the concept of clinical exemplars. An experienced practitioner observes clinical events, analyzes them to make new connections between events and ideas, and produces a synthesized whole. Clinical exemplars provide outstanding models of the actions of individual RDs in diabetes care in clinical settings and the professional activities that have enhanced patient/client care. Clinical exemplars include a brief description of the need for action and the process used to change the outcome.

FUTURE DIRECTIONS

The revised SOP and SOPP for RDs in diabetes care are innovative and dynamic documents. Future revisions will reflect changes in practice, dietetics education programs, and outcomes of practice audits. The three practice levels require more clarity and differentiation in content and role delineation and competency statements that better characterize differences among the practice levels are needed. Creation of this clarity, differentiation, and definition are the challenges of today's RDs in diabetes care to better serve tomorrow's practitioners and their patients, clients, and customers.

CONCLUSIONS

The revised SOP and SOPP for RDs in diabetes care are complementary documents and are key resources for RDs at all knowledge and performance levels. These standards can and should be used by RDs in daily practice to consistently improve and appropriately demonstrate competency and value as providers of safe and effective diabetes care. These standards also serve as a professional resource for self-evaluation and professional development for RDs specializing in diabetes care. The development and evaluation process is dynamic. Just as a professional's self-evaluation and continuing education process is an ongoing cycle, these standards are also a work in progress and will be reviewed and updated every 5 years. Current and future initiatives of ADA will provide information to use in these updates and in further clarifying and documenting the specific roles and responsibilities of RDs at each level of practice. As a quality initiative of ADA and the DCE DPG, these standards are an application of continuous quality improvement and represent an important collaborative endeavor.

These standards have been formulated to be used for individual self-evaluation and the development of practice guidelines, but not for institutional credentialing or for adverse or exclusionary decisions regarding privileging, employment opportunities or benefits, disciplinary actions, or determinations of negligence or misconduct. These standards do not constitute medical or other professional advice, and should not be taken as such. The information presented in these standards is not a substitute for the exercise of professional judgment by a health care professional. The use of the standards for any other purpose than that for which they were formulated must be undertaken within the sole authority and discretion of the user.

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Glossary of Terms for the Revised SOP and SOPP for RDs in Diabetes Care

AADE7: The American Association of Diabetes Educators (AADE) has defined the AADE7 Self-Care Behaviors as a framework for patient-centered diabetes education and care. The seven self-care behaviors essential for successful and effective diabetes self-management are healthy eating, being active, monitoring, taking medication, problem solving, healthy coping, and reducing risks. The AADE7 Self-Care Behaviors provide an evidence-based framework for assessment, intervention, and outcome (evaluation) measurement of the diabetes patient, program, and population (39-41).

Chronic care model: Comprehensive evidence-based model used in chronic disease prevention and management (42).

Clinical microsystem: A health care framework that focuses on safety and quality of care to reduce medical errors and to promote harm reduction (43).

Competence: The “ability to demonstrate appropriate professional behaviors with desirable outcomes. Professionals who are competent use up-to-date knowledge and skills; make sound decisions based on appropriate data; communicate effectively with patients, customers, and other professionals; critically evaluate their own practice; and improve performance based on self-awareness, applied practice, and feedback from others” (44).

Diabetes Control and Complications Trial (DCCT): A study by the National Institute of Diabetes and Digestive and Kidney Diseases, conducted from 1983 to 1993 in people with type 1 diabetes. The study showed that intensive therapy compared to conventional therapy significantly helped prevent or delay diabetes complications. Intensive therapy included multiple daily insulin injections or the use of an insulin pump with multiple blood glucose readings each day. Complications followed in the study included diabetic retinopathy, neuropathy, and nephropathy (45).

Diabetes Prevention Program (DPP): A study by the National Institute of Diabetes and Digestive and Kidney Diseases conducted from 1998 to 2001 in people at high risk for type 2 diabetes. All study participants had impaired glucose tolerance, also called pre-diabetes, and were overweight. The study showed that people who lost 5% to 7% of their body weight through a low-fat, low-calorie diet and moderate exercise (usually walking for 30 minutes 5 days a week) reduced their risk of getting type 2 diabetes by 58%. Participants who received treatment with the oral diabetes drug metformin reduced their risk of getting type 2 diabetes by 31% (46).

Diabetes self-management training (DSMT): Under Medicare Part B, “diabetes outpatient self-management training services means educational and training services furnished . . . to an individual with diabetes by a certified provider . . . in an outpatient setting by an individual or entity who meets the quality standards . . . , but only if the physician who is managing the individual’s diabetic condition certifies that such services are needed under a comprehensive plan of care related to the individual’s diabetic condition to ensure therapy compliance or to provide the individual with necessary skills and knowledge (including skills related to the self-administration of injectable drugs) to participate in the management of the individual’s condition.” (47) “The program includes instructions in self-monitoring of blood glucose; education about diet and exercise; an insulin treatment plan developed specifically for the patient who is insulin-dependent; and motivation for patients to use the skills for self-management. (48) Under Medicare Part B, all DSMT programs must be accredited as meeting quality standards by a Centers for Medicare & Medicaid Services–approved national accreditation organization. Currently, the Centers for Medicare & Medicaid Services recognize the American Diabetes Association Education Recognition Program and the American Association of Diabetes Educators Diabetes Education Accreditation Program as approved national accreditation organizations (49).

Diabetes Self-Management Education (DSME): “Diabetes education, also referred to as diabetes self-management education or diabetes self-management training, is performed by health care professionals who have appropriate credentials and experience consistent with the particular profession’s scope of practice.”

“DSME involves the person with pre-diabetes or diabetes and/or the caregivers and the educator(s) and is defined as the ongoing process of facilitating the knowledge, skill, and ability necessary for self-care. It is a component of a comprehensive plan of diabetes care. The process incorporates the needs, goals and life experiences of the person with pre-diabetes or diabetes and is guided by evidence-based standards. The overall objectives of DSME are to support informed decision-making, self-care behaviors, problem-solving and active collaboration with the health care team and to improve clinical outcomes, health status, and quality of life. The process includes:

- An individual assessment and education plan developed collaboratively by the individual and educator(s) to direct the selection of appropriate educational interventions and self-management support strategies.
- Educational interventions directed toward helping the individual achieve self-management goals.
- Periodic evaluations to determine attainment of educational objectives or need for additional interventions and future reassessments.
- A personalized follow-up plan developed collaboratively by the individual and educator(s) for ongoing self-management support.
- Documentation in the education record of the assessment and education plan and the intervention and outcomes.”

(Adapted from *National Standards for Diabetes Self-Management Education*, American Diabetes Association Clinical Practice Recommendations. *Diabetes Care*, Vol. 32, Supplement 1, January, 2009 [50].)

Differential nutrition diagnosis: A systematic process of considering various possible nutrition diagnoses, considering the characteristics of each diagnosis in comparison to an individual's presentation, and arriving at a specific nutrition diagnosis. Nutrition diagnoses are well defined in the International Dietetics and Nutrition Terminology Reference Manual, 3rd edition (51).

Evidence-based dietetics practice: The use of systematically reviewed scientific evidence in making food and nutrition practice decisions by integrating best available evidence with professional expertise and client values to improve outcomes (44).

Health literacy: The ability to use reading, writing, and computational skills at a level adequate to meet the needs of everyday situations (52).

Health numeracy: The degree to which individuals have the capacity to access, process, interpret, communicate, and act on numerical, quantitative, graphical, biostatistical, and probabilistic health information needed to make effective health decisions (53).

Intensive therapy: "A treatment for diabetes in which blood glucose is kept as close to normal as possible through frequent injections or use of an insulin pump; meal planning; adjustment of medicines; and exercise based on blood glucose test results and frequent contact with a person's health care team" (54).

Medical nutrition therapy (MNT): "Medical nutrition therapy (MNT) is an evidence-based application of the Nutrition Care Process focused on prevention, delay or management of diseases and conditions, and involves an in-depth assessment, periodic re-assessment and intervention" (44).

MNT services are defined in federal (Medicare Part B) statute as "nutritional diagnostic, therapy, and counseling services for the purpose of disease management which are furnished by a registered dietitian or nutrition professional . . . pursuant to a referral by a physician." MNT is provided by licensed/certified (as applicable) registered dietitians and nutrition professionals (55).

Nutrition Care Process and Model: A systematic problem-solving method that food and nutrition professionals use to think critically and make decisions that address practice-related problems (56).

Nutrition diagnosis: A critical step in the Nutrition Care Process (NCP) in which the practitioner identifies a nutrition problem that can be addressed with nutrition intervention (51).

Nutrition focused physical findings: Part of the assessment phase of the NCP. A skilled practitioner evaluates several aspects of the client's appearance, including hair, skin, eyes, oral cavity, nails, gastrointestinal symptoms (such as appetite, bowel function, nausea, altered taste), neurological findings (confusion, for example), and vital signs (51).

United Kingdom Prospective Diabetes Study: (UKPDS) – A study in the United Kingdom, conducted from 1977 to 1997 in people with Type 2 diabetes. "The study showed that if people lowered their blood glucose, they lowered their risk of eye disease and kidney damage. In addition, those with Type 2 diabetes and hypertension who lowered their blood pressure also reduced their risk of stroke, eye damage, and death from long-term complications" (54,57).

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Standards of Practice are authoritative statements that describe a competent level of practice demonstrated through nutrition assessment, nutrition diagnosis (problem identification), nutrition intervention (planning, implementation), and outcomes monitoring and evaluation (four separate standards) and the responsibilities for which registered dietitians (RDs) are accountable. The Revised Standards of Practice in Diabetes Care presuppose that the RD uses critical thinking skills, analytical abilities, theories, best available research findings, current accepted dietetics and medical knowledge, and the systematic holistic approach of the nutrition care process as they relate to the standards. The Revised Standards of Professional Performance in Diabetes Care are authoritative statements that describe a competent level of behavior in the professional role, including activities related to provision of services; application of research; communication and application of knowledge; utilization and management of resources; quality in practice; and continued competence and professional accountability (six separate standards).

Standards of Practice and Standards of Professional Performance are complementary sets of standards - both serve to completely describe the practice and professional performance of dietetics. All indicators may not be applicable to all RDs' practice or to all practice settings and situations. RDs must be aware of federal and state laws affecting their practice as well as organizational policies and guidelines. The standards are a resource but do not supersede laws, policies, and guidelines.

The term patient/client is used in this evaluation resource as a universal term. Patient/client could also mean client, patient, customer, participant, consumer, or any individual or group who receives diabetes care. Diabetes care and education services are provided to individuals of all ages. These Standards of Practice and Standards of Professional Performance are not limited to the clinical setting. In addition, it is recognized that the family and caregiver(s) of patients of all ages, including individuals with special health care needs, play critical roles in overall health and are important members of the team throughout the assessment and intervention process. The term "appropriate" is used in the standards to mean: Selecting from a range of best practice or evidence-based possibilities, one or more of which would give an acceptable result in the circumstances.

Each standard is equal in relevance and importance and includes a definition, a rationale statement, indicators, and examples of desired outcomes. A standard is a collection of specific outcome-focused statements against which a practitioner's performance can be assessed. The rationale statement describes the intent of the standard and defines its purpose and importance in greater detail. Indicators are measurable action statements that illustrate how each specific standard can be applied in practice. Indicators serve to identify the level of performance of competent practitioners and to encourage and recognize professional growth.

Standard definitions, rationale statements, core indicators, and examples of outcomes found in the American Dietetic Association Standards of Practice in Nutrition Care and Standards of Professional Performance have been adapted to reflect three levels of practice (generalist, specialty, and advanced) in diabetes care. In addition, the core indicators have been expanded upon to reflect the unique competence expectations of the RD in diabetes care.

Standards described as specialty level of practice in this document are not equivalent to the National Certification Board for Diabetes Educators (NCBDE) certification, Certified Diabetes Educator (CDE). Rather, the CDE designation recognizes the skill level of an RD who has developed diabetes nutrition knowledge and application beyond the generalist practitioner. An RD with a CDE designation is an example of an RD who has demonstrated, at a minimum, specialty level skills as presented in this document. Standards described as advanced level of practice in this document are not equivalent to the American Association of Diabetes Educators (AADE) certification, Board Certified-Advanced Diabetes Management (BC-ADM). Rather, the BC-ADM designation recognizes the skill level of an RD who has developed diabetes nutrition knowledge and application beyond the specialty level practitioner. An RD with a BC-ADM designation is an example of an RD who has demonstrated, at a minimum, advanced level skills as presented in this document.

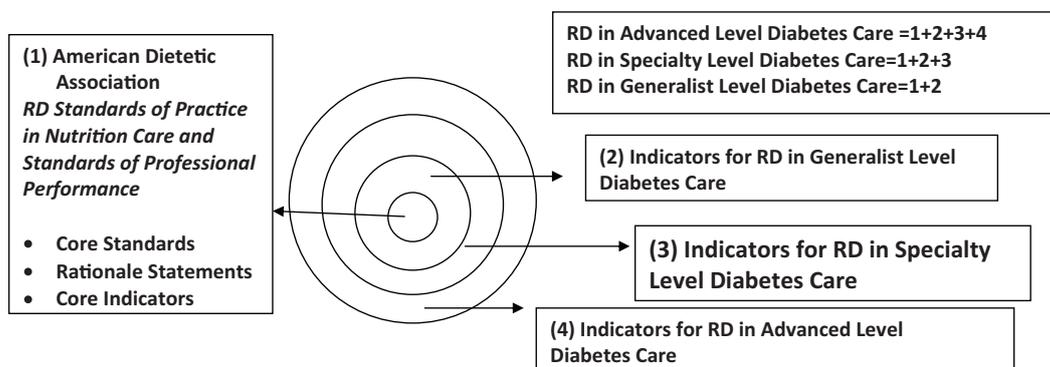


Figure 1. Revised Standards of Practice and Standards of Professional Performance for Registered Dietitians (Generalist, Specialty and Advanced) in Diabetes Care.

Standard 1: Nutrition Assessment:
Registered dietitians (RDs) use accurate and relevant data and information to identify nutrition-related problems.
Rationale: Nutrition assessment is the first of four steps of the Nutrition Care Process. Nutrition Assessment is a systematic process of obtaining, verifying, and interpreting data in order to make decisions about the nature and cause of nutrition-related problems. It is initiated by referral and/or screening of individuals or groups for nutrition risk factors. Nutrition Assessment is an ongoing, dynamic process that involves not only initial data collection, but also reassessment and analysis of client or community needs. It provides the foundation for Nutrition Diagnosis, the second step of the Nutrition Care Process.

Indicators for Standard 1: Nutrition Assessment (Bold Font Indicators are American Dietetic Association (ADA) Core RD Standards of Practice Indicators)				The "X" signifies the indicators for the level of practice		
				Generalist	Specialty	Advanced
<i>Each RD:</i>						
1.1	Evaluates dietary intake for factors that affect health and conditions including nutrition risk			X	X	X
	1.1A	Evaluates adequacy and appropriateness of food, beverage and nutrient intake (eg, macro and micronutrients; meal patterns; food allergies)		X	X	X
		1.1A1	Evaluates appetite changes and possible associated gastrointestinal problems (eg, problems with chewing and swallowing, reflux, vomiting, diarrhea, constipation, irritable bowel syndrome, gastroparesis)	X	X	X
		1.1A2	Evaluates type and distribution of macronutrient intake	X	X	X
	1.1B	Assesses adequacy and appropriateness of current diet prescription		X	X	X
		1.1B1	Evaluates current meal planning approach (eg, carbohydrate counting, Exchange Lists for Meal Planning, calorie counting, food pyramid, plate method)	X	X	X
1.2	Evaluates health and disease condition(s) for nutrition related consequences			X	X	X
	1.2A	Evaluates diabetes history, medical history, and family history comorbidities, substance use and abuse behavior and preventative care		X	X	X
		1.2A1	Evaluates diabetes history; including assessment of diabetes self-management education/training, skills and behaviors (DSME/T) (eg, National Standards for Diabetes Self Management Education—Standard 3; American Association of Diabetes Educators-7 (AADE7) Self-Care Behaviors—healthy eating, being active, monitoring, taking medication, problem solving, healthy coping, reducing risks)	X	X	X
		1.2A2	Evaluates diabetes history of the intensively managed patient/client, including self-management education/training, skills and behaviors, (eg, insulin pump therapy and/or use of continuous glucose monitoring [CGM])		X	X
		1.2A3	Evaluates medical history of health, disease conditions and other comorbidities, (eg, cardiovascular disease, lipid disorders, hypertension, overweight/obesity, kidney disease, peripheral vascular disease, cancer, gastric bypass/banding, stroke, chronic obstructive pulmonary disease [COPD], congestive heart failure [CHF])	X	X	X
		1.2A4	Evaluates family history (eg, diabetes, cardiovascular disease, lipid disorders, hypertension, overweight/obesity, kidney disease, cancer, peripheral vascular disease, stroke)	X	X	X
		1.2A5	Reviews the history of previous diabetes nutrition care services/medical nutrition therapy	X	X	X
		1.2A6	Evaluates associated autoimmune comorbidities, (eg, thyroid conditions, Addison's disease, celiac disease, cystic fibrosis related diabetes, pernicious anemia)	X	X	X
		1.2A7	Determines history of tobacco, alcohol, drug use	X	X	X

Figure 2. American Dietetic Association Revised Standards of Practice for Registered Dietitians (Generalist, Specialty, and Advanced) in Diabetes Care.

Indicators for Standard 1: Nutrition Assessment			The "X" signifies the indicators for the level of practice		
(Bold Font Indicators are American Dietetic Association (ADA) Core RD Standards of Practice Indicators)			Generalist	Specialty	Advanced
<i>Each RD:</i>					
1.2B	Evaluates physical findings (eg, physical or clinical exam)		X	X	X
	1.2B1	Assesses anthropometric measurements (eg, body mass index, waist circumference and/or waist-to-hip ratio)	X	X	X
	1.2B2	Utilizes recommendations from American Medical Association (AMA)—Physician Quality Reporting Initiative (PQRI) Measures and American Diabetes Association Standards of Medical Care (diabetes.org) as benchmark tools when evaluating physical or clinical findings, (eg, objective screening of sensory sensitivity/ neuropathy using monofilament testing or other tools, urine protein screening, blood pressure, foot and eye exam)		X	X
	1.2B3	Performs nutrition-focused physical examination that includes but is not limited to: injection sites; feet for signs of irritation from shoes, or dry or cracked skin; other body areas for skin conditions related to diabetes (eg, wound, Acanthosis Nigricans or Vitiligo)		X	X
1.2C	Assesses and reviews medication adherence and management (eg, prescription, over-the-counter, and herbal medications; medication allergies; medication/food interaction)		X	X	X
	1.2C1	Assesses the prescription, dosage and adherence to insulin, other injectables, and/or oral diabetes medications (i.e., type, dosage, effect, duration)	X	X	X
	1.2C2	Assesses current medication regimen, other injectables, and/or oral diabetes medications in relation to food intake and timing of administration of medication		X	X
	1.2C3	Assesses current insulin regimen—mealtime and correction insulin dosing factors (eg, insulin to carbohydrate ratios, insulin sensitivity factor, exercise correction)		X	X
	1.2C4	Assesses nutrition-related side effects (including alterations in absorption, metabolism, or excretion of nutrients) of other prescription medications used long term	X	X	X
	1.2C5	Considers the safety and efficacy of over-the-counter medications, herb/dietary supplements	X	X	X
	1.2C6	Assesses, as part of the multidisciplinary team, the need to add or discontinue medications or adjust the dose and timing of medications		X	X
	1.2C7	Evaluates the relationships between prescription, over-the-counter, and other medications and herb/dietary supplements that are being used by the patient/client; identifies specific medications and herb/dietary supplements that may affect blood glucose level		X	X
	1.2C8	Evaluates overall medication management in the context of integrated disease state management			X
1.2D	Evaluates diagnostic tests, biochemical data, diabetes device and equipment use, patient/client records, procedures, evaluations		X	X	X
	1.2D1	Uses clinical practice recommendations as basis for tests recommended to diagnose diabetes or pre-diabetes (eg, Hemoglobin A1c [HbA1c], oral glucose tolerance test), procedures and evaluations (eg, nationally developed evidenced based diabetes guidelines and standards)	X	X	X
	1.2D2	Evaluates biochemical laboratory data for lipids, glucose, kidney function, other nutrition-related tests, and blood pressure measurements	X	X	X

Figure 2. (Continued)

Indicators for Standard 1: Nutrition Assessment				The "X" signifies the indicators for the level of practice		
(Bold Font Indicators are American Dietetic Association (ADA) Core RD Standards of Practice Indicators)				Generalist	Specialty	Advanced
<i>Each RD:</i>						
	1.2D3	Evaluates blood glucose data and reports (eg, patient/client records and/or electronically generated reports)		X	X	X
	1.2D4	Evaluates selection and use of blood glucose monitoring equipment			X	X
	1.2D5	Evaluates administration technique of insulin, other injectables, and appropriateness of medication delivery device (eg, syringe, pen, or pump), glucagon administration technique, urine or blood ketone testing when appropriate			X	X
	1.2D6	Uses patient/client reported food intake, blood glucose data, and/or diabetes medication records for pattern management evaluation			X	X
	1.2D7	Evaluates insulin pump therapy and CGM data and records (eg, manual review of device settings, and/or electronically generated data reports)			X	X
	1.2D8	Utilizes tests, procedures, and evaluations and incorporates complex decision-making in the context of integrated disease state management				X
1.2E	Identifies and assesses diabetes complications (acute and chronic) and risk reduction/prevention			X	X	X
	1.2E1	Assesses evidence-based indicators of diabetes-related complications (eg, lipids, microalbumin, blood pressure, inflammatory markers)		X	X	X
	1.2E2	Assesses risk of developing acute complications (eg, hypoglycemia, hyperglycemia, diabetic ketoacidosis [DKA])		X	X	X
	1.2E3	Assesses and reviews frequency, severity and consequences of hypoglycemia/hyperglycemia, and prevention/treatment			X	X
	1.2E4	Assesses patient/client understanding of the most common precipitants of DKA (eg, an increased requirement for insulin due to an increased physiologic stress such as seen with an infection, trauma, or omission of normal insulin) and behaviors leading to DKA			X	X
	1.2E5	Assesses actual risk of developing chronic microvascular complications (eg, neuropathy, nephropathy, retinopathy)			X	X
	1.2E6	Assesses risk of developing chronic macrovascular complications (eg, cardiovascular disease)			X	X
	1.2E7	Determines readiness of patient/client for intensifying glycemic control to prevent or reduce the progression of chronic complications as appropriate			X	X
	1.2E8	Assesses preventive care behaviors (eg, foot care, annual influenza immunization, pneumococcal immunization, annual dilated eye and dental exams) based on the recommendations of the American Diabetes Association Standards of Medical Care (www.diabetes.org)			X	X
	1.2E9	Directs nutrition management of long-term complications of diabetes within the context of integrated care				X
1.2F	Evaluates the patient's/client's physical activity level and identifies activity limitations			X	X	X
	1.2F1	Evaluates current diabetes treatment plan for appropriate physical activity prescription according to current guidelines		X	X	X
	1.2F2	Assesses physical activity limitations (eg, vision, mobility, dexterity, medication contraindications)		X	X	X
	1.2F3	Assesses ability to perform physical activity in the presence of suboptimal blood glucose control and specific long-term complications of diabetes			X	X

Figure 2. (Continued)

Indicators for Standard 1: Nutrition Assessment		The "X" signifies the indicators for the level of practice		
(Bold Font Indicators are American Dietetic Association (ADA) Core RD Standards of Practice Indicators)		Generalist	Specialty	Advanced
<i>Each RD:</i>				
1.3	Evaluates psychosocial, socioeconomic, functional, and behavioral factors related to food access, selection, preparation, and understanding of health condition	X	X	X
1.3A	Utilizes validated tools to assess developmental, functional, and mental status, and cultural, ethnic, and lifestyle factors	X	X	X
	1.3A1 Assesses health literacy and numeracy (eg, ability to read, write, and perform calculations)	X	X	X
	1.3A2 Evaluates nutrition and health knowledge and beliefs	X	X	X
	1.3A3 Explores factors indicating risk of depression	X	X	X
	1.3A4 Assesses risk/history of disordered eating and factors related to risk (eg, medication adjustments/omissions, food issues, physical activity)	X	X	X
	1.3A5 Assesses food access and availability	X	X	X
1.4	Evaluates patient/client readiness to learn and potential for behavior changes	X	X	X
1.4A	Assesses behavioral mediators (or antecedents) related to dietary intake (eg, attitudes, self-efficacy, knowledge, intentions, readiness and willingness to change, perceived social support)	X	X	X
1.4B	Identifies self-care skills and behaviors	X	X	X
1.4C	Assesses feelings about living with diabetes and living with chronic disease		X	X
1.4D	Assesses lifestyle behaviors related to diabetes complications		X	X
1.5	Compares patient/client data with national standards of diabetes care (HbA1c, blood pressure, lipids)	X	X	X
1.6	Identifies possible problem areas for determining nutrition diagnoses	X	X	X
1.6A	Assesses more complex issues related to food intake and clinical complications		X	X
1.6B	Assesses most complex issues related to food intake and clinical complications and their management within the multidisciplinary treatment			X
1.7	Documents the patient/client assessment:	X	X	X
1.7A	Date and time of assessment	X	X	X
1.7B	Pertinent data and comparison to standards	X	X	X
1.7C	Patient/client current perceptions, values, and motivation related to presenting problems	X	X	X
1.7D	Changes in patient/client perceptions, values, and motivation related to presenting problems	X	X	X
1.7E	Reason for discharge/discontinuation or referral if appropriate	X	X	X

Examples of Outcomes for Standard 1: Nutrition Assessment

- Appropriate assessment tools and procedures (matching the assessment method to the situation) are implemented
- Assessment tools are applied in valid and reliable ways
- Appropriate data are collected
- Data are validated
- Data are collected, organized and categorized in a meaningful framework that relates to nutrition problems
- Effective interviewing methods are utilized
- Problems that require consultations with or referral to another provider are recognized and addressed
- Documentation and communication of assessment are complete, relevant, accurate, and timely

Figure 2. (Continued)

Standard 2: Nutrition Diagnosis
RDs identify and label specific nutrition problem(s) that the RD is responsible for treating.

Rationale: Nutrition Diagnosis is the second of four steps of the Nutrition Care Process. At the end of the Nutrition Assessment step, data are clustered, analyzed, and synthesized. This will reveal a nutrition diagnosis category from which to formulate a specific nutrition diagnosis statement. There is a difference between a nutrition diagnosis and a medical diagnosis. A nutrition diagnosis changes as the patient/client response changes, whereas a medical diagnosis does not change as long as the disease or condition exists. The nutrition diagnosis(es) demonstrates a link to determining goals for outcomes, selecting appropriate interventions and tracking progress in attaining expected outcomes.

Standard 2: Nutrition Diagnosis		The "X" signifies the indicators for the level of practice		
		Generalist	Specialty	Advanced
(Bold Font Indicators are ADA Core RD Standards of Practice Indicators)				
<i>Each RD:</i>				
2.1	Derives the nutrition diagnosis(es) from the assessment data	X	X	X
	2.1A Identifies and labels the problem	X	X	X
	2.1B Determines etiology (cause/contributing risk factors)	X	X	X
	2.1C Clusters signs and symptoms (defining characteristics)	X	X	X
2.2	Ranks (prioritizes) the nutrition diagnosis(es)	X	X	X
	2.2A Uses evidence-based protocols and guidelines for diabetes care to prioritize nutrition diagnoses in order of importance or urgency	X	X	X
	2.2B Uses experience, in addition to protocols and guidelines for diabetes care, to determine nutrition diagnosis hierarchy for disease states and complications		X	X
	2.2C Prioritizes nutrition diagnoses for disease states and complications as base for protocols and guidelines, using advanced diagnostic reasoning and judgment			X
2.3	Validates the nutrition diagnosis(es) based on assessment data and input from patient/client, community, family members, and/or other health care professionals when possible and appropriate	X	X	X
	2.3A Validates the diagnosis(es) using specialty level clinical judgment skills (eg, selects from a range of possibilities with additional consideration of the prevention of micro- and macrovascular complications)		X	X
	2.3B Validates the diagnosis(es) using advanced diagnostic reasoning and judgment (ie, reflecting the holistic focus of diabetes as a complex metabolic disorder)			X
2.4	Documents the nutrition diagnosis(es) using standardized language and written statement(s) that include problem (P), etiology (E) and signs and symptoms (S) (PES statement[s])	X	X	X
2.5	Re-evaluates and revises nutrition diagnosis(es) when additional assessment data become available	X	X	X

Examples of Outcomes for Standard 2: Nutrition Diagnosis

- Nutrition Diagnosis Statements that are:
 - Clear and concise
 - Specific—patient/client or community centered
 - Accurate—relates to etiology
 - Based on reliable and accurate assessment data
 - Includes date and time
- Documentation of nutrition diagnosis(es) is relevant, accurate and timely
- Documentation of nutrition diagnosis(es) is revised and updated as additional assessment data become available

Figure 2. (Continued)

Standard 3: Nutrition Intervention

RDs identify and implement appropriate, purposefully planned actions designed with the intent of changing a nutrition-related behavior, risk factor, environmental condition, or aspect of health status for an individual, target group, or the community at large.

Rationale: Nutrition Intervention is the third of four steps of the Nutrition Care Process. It consists of two interrelated components—planning and implementation. Planning involves prioritizing the nutrition diagnoses, conferring with the patient/client and/or others, reviewing practice guides and policies, and setting goals and defining the specific nutrition intervention strategy. Implementation of the nutrition intervention is the action phase that includes carrying out and communicating the plan of care, continuing data collection, and revising the nutrition intervention strategy, as warranted, based on the patient/client response. The RD performs the interventions or assigns the nutrition care that others provide in accordance with federal, state, and local laws and regulations.

Standard 3: Nutrition Intervention		The “X” signifies the indicators for the level of practice		
		Generalist	Specialty	Advanced
(Bold Font Indicators are ADA Core RD Standards of Practice Indicators)				
<i>Each RD:</i>				
<i>Plans the nutrition intervention:</i>				
3.1	Prioritizes the nutrition diagnosis based on problem severity, safety, patient/client needs, likelihood that nutrition intervention will impact problem and patient/client perception of importance	X	X	X
Prioritization considerations may include:				
3.1A	Survival skills (eg, glycemic response to macronutrients, meal timing, self-blood glucose monitoring, action of medication[s], and treatment of hypoglycemia)	X	X	X
3.1B	DSME/DSMT needs (eg, AADE7 Behaviors, National DSME Standards)	X	X	X
3.1C	Comorbid diseases or conditions (eg, obesity, CHF, hypertension, dyslipidemia, depression, kidney disease, COPD, eating disorders)	X	X	X
3.1D	Actual or risk for acute complications (eg, hypoglycemia, hyperglycemia, and diabetic ketoacidosis)	X	X	X
3.1E	Actual or risk of micro- and macrovascular complications	X	X	X
3.1F	Appropriateness of patient/client for intensive glycemic control to prevent or reduce the progression of chronic complications based on comorbidities		X	X
3.2	Selects specific intervention plan based on best available evidence (eg, national guidelines [American Diabetes Association Standards of Medical Care], published research, evidence-based libraries [ADA Evidence Analysis Library] and databases)	X	X	X
3.2A	Evaluates and selects appropriate guidelines		X	X
3.2B	Adjusts guidelines/protocols based on the individual and progress of intervention		X	X
3.2C	Recognizes when it is appropriate and safe to deviate from established guidelines			X
3.3	Considers institutional program policies and protocols when selecting an intervention plan	X	X	X
3.4	Discusses intervention plan with patient/client and caregivers, as appropriate	X	X	X
3.5	Determines patient/client-focused goals and expected outcomes	X	X	X
3.5A	Develops expected goals and outcomes with the patient/client in observable and measurable terms that are clear and concise	X	X	X
3.5B	Develops patient/client-centered goals and outcomes tailored to what is reasonable to the patient/client’s circumstances	X	X	X

Figure 2. (Continued)

Standard 3: Nutrition Intervention			The "X" signifies the indicators for the level of practice		
(Bold Font Indicators are ADA Core RD Standards of Practice Indicators)			Generalist	Specialty	Advanced
<i>Each RD:</i>					
<i>Plans the nutrition intervention:</i>					
3.6	Details the diabetes self-care plan including the nutrition prescription		X	X	X
	3.6A	Reviews diabetes meal-planning approach and develops or adjusts individualized diabetes meal plan as indicated	X	X	X
	3.6B	Defines pharmacotherapy intervention plan	X	X	X
	3.6B1	Reviews insulin, incretins, and oral diabetes medications (eg, effect on blood glucose level)	X	X	X
	3.6B2	Recommends the initiation of pharmacotherapy. (May include calculation of insulin-to-carbohydrate ratios [ICR]; calculating and explaining insulin sensitivity factor [ISF]; use and application of ISF; intensification of medication management based on progression of the disease.)		X	X
	3.6B3	Recommends adjustments to pharmacotherapy, based on integration of nutrition, physical activity, medication, blood glucose and/or CGM data, and physical exam data. (May include adjustment of ICR and ISF; intensification of medication management based on progression of the disease.)		X	X
	3.6B4	Provides instruction on medication delivery systems, which may include insulin or incretins (eg, syringes, pens, insulin pump); stability, storage and compatibility; reducing risk of blood-borne pathogens and sharps' disposal.		X	X
	3.6B5	Implements pharmacotherapy plan, including adjustments, using provider-approved protocols consistent with facility policies. Uses advanced judgment and reasoning, integrating nutrition, physical activity, medication, blood glucose and/or CGM data, and physical exam data			X
	3.6B6	Discusses complementary and alternative treatment strategies when medically appropriate			X
	3.6C	Discusses acute complications such as treatment of hyper- and hypoglycemia	X	X	X
	3.6C1	Reviews basic information and provides instruction on prevention and treatment for hyper- and hypoglycemia; reviews laboratory test results (eg, HbA1c, lipids) and provides instruction on relevance to treatment	X	X	X
	3.6C2	Provides instruction on treatment of severe hypoglycemia to include administration of glucagon		X	X
	3.6D	Discusses sick-day guidelines	X	X	X
	3.6D1	Provides information for sick-day guidelines beyond food intake (eg, medication adjustment, urine or blood ketone testing, adequate hydration)		X	X
	3.6E	Discusses glucose monitoring data	X	X	X
	3.6E1	Provides recommendation to health care provider that adjustment in medication is needed based on analysis of glucose monitoring data	X	X	X
	3.6E2	Provides instruction on glucose data in relation to food intake and makes recommendations for adjustments in food plan and/or diabetes medications		X	X
	3.6E3	Provides instruction on glucose data in relation to physical activity and makes recommendations in food plan and/or diabetes medications		X	X
	3.6E4	Plans and reviews selection and initiation of glucose monitoring equipment (eg, blood glucose meters, continuous glucose monitoring systems, sensor-augmented pumps)		X	X
	3.6E5	Provide instruction on basic trending of glucose; how to use personal data management tools for review and interpreting glucose patterns (home use)			X

Figure 2. (Continued)

Standard 3: Nutrition Intervention				The "X" signifies the indicators for the level of practice		
(Bold Font Indicators are ADA Core RD Standards of Practice Indicators)				Generalist	Specialty	Advanced
<i>Each RD:</i>						
<i>Plans the nutrition intervention:</i>						
	3.6F	Discusses reducing risk of chronic complications		X	X	X
		3.6F1	Discusses reduction of chronic complications, including, but not limited to, foot exam, blood pressure and lipid control, annual eye and dental examinations	X	X	X
		3.6F2	Reviews components of comprehensive foot care that include the following: awareness of personal risk factors, importance of at least annual inspection of feet by a health care professional, daily self-inspection of feet, proper nail and skin care, injury prevention, and when to seek help or specialized referral		X	X
	3.6G	Integrates psychological and behavioral factors into the nutrition prescription		X	X	X
3.7	Defines frequency of care and expected duration needed for intervention			X	X	X
	3.7A	Determines intensity of change and uses to determine duration and follow-up			X	X
3.8	Utilizes standardized language for describing interventions			X	X	X
3.9	Evaluates patient/client readiness to learn, and potential for behavior changes			X	X	X
	3.9A	Identifies resources to assist patient/client with diabetes (eg, using health care and diabetes education services, support groups, and community programs appropriately)		X	X	X
	3.9B	Recommends referrals to programs and/or providers (eg, behavioral health, ophthalmologist, podiatrist, and dentist) as appropriate		X	X	X
<i>Implements the Nutrition Intervention:</i>						
3.10	Collaborates with health care colleagues outside of the diabetes care team to ensure quality of care for the patient/client (eg, weight management, heart disease, cystic fibrosis, renal disease, eating disorders)			X	X	X
	3.10A	Facilitates and fosters active communication, learning, partnerships, and collaboration with the diabetes team			X	X
3.11	Communicates the plan of care to referring providers and others as needed			X	X	X
3.12	Initiates the plan of care with the patient/client			X	X	X
	3.12A	Addresses topics with patient/client/family/support person as outlined in the nutrition prescription (eg, meal planning approach, pharmacotherapy intervention, acute and chronic complications, risk of chronic complications, sick-day guidelines, glucose monitoring data)		X	X	X
	3.12B	Utilizes appropriate behavior change theories (eg, motivational interviewing, behavior modification, modeling) to facilitate self management self-care strategies		X	X	X
	3.12C	Uses critical thinking and synthesis skills to guide decision-making in complicated, unpredictable, and dynamic situations			X	X
3.13	Continues data collection and modifies the plan of care as needed			X	X	X
	3.13A	Conducts comprehensive analysis of data trends to modify the plan of care, as indicated			X	X
	3.13B	Develops policies for data analysis				X

Figure 2. (Continued)

Standard 3: Nutrition Intervention			The "X" signifies the indicators for the level of practice		
(Bold Font Indicators are ADA Core RD Standards of Practice Indicators)			Generalist	Specialty	Advanced
<i>Each RD:</i>					
<i>Implements the Nutrition Intervention:</i>					
3.14	Individualizes nutrition intervention		X	X	X
	3.14A	Uses interpersonal, teaching, coaching, counseling, health literacy, and numeracy resources and/or technological approaches as appropriate	X	X	X
	3.14B	Uses critical thinking synthesis skills for combining multiple intervention approaches as appropriate		X	X
	3.14C	Draws on experiential knowledge and current body of advanced knowledge about the patient/client population to individualize the strategy for complex interventions			X
3.15	Follows up and verifies that nutrition intervention is occurring and needs are being met		X	X	X
3.16	Adjusts nutrition intervention strategies, when appropriate		X	X	X
	3.16A	Makes adjustments in complicated situations using critical thinking and synthesis skills to guide decision-making (eg, glycemic variability or comorbidities)		X	X
3.17	Documents:		X	X	X
	3.17A	Date, time of day, duration and type (ie, individual or group) of intervention	X	X	X
	3.17B	Treatment goals and expected outcomes	X	X	X
	3.17C	Recommended interventions	X	X	X
	3.17D	Adjustments to the plan and justification	X	X	X
	3.17E	Patient/client receptivity, barriers, and comprehension	X	X	X
	3.17F	Educational material(s) provided	X	X	X
	3.17G	Referrals made and resources used	X	X	X
	3.17H	Other information relevant to providing care and monitoring progress over time	X	X	X
	3.17I	Plans for follow up and frequency of care	X	X	X
	3.17J	Documents reason for discharge/discontinuation or referral as appropriate	X	X	X

Examples of Outcomes for Standard 3: Nutrition Intervention

- Appropriate prioritizing and setting of goals/expected outcomes
- Appropriate nutrition plan or prescription is developed
- Interdisciplinary connections are established
- Nutrition interventions are delivered and actions are carried out
- Documentation of nutrition intervention is:
 - Comprehensive
 - Specific
 - Accurate
 - Relevant
 - Timely
 - Dated and timed
- Documentation of nutrition intervention is revised and updated

Figure 2. (Continued)

Standard 4: Nutrition Monitoring and Evaluation

RDs monitor and evaluate indicators and outcomes data directly related to the nutrition diagnosis, goals and intervention strategies to determine the progress made in achieving desired outcomes of nutrition care and whether planned interventions should be continued or revised.

Rationale: Nutrition monitoring and evaluation is the fourth step in the Nutrition Care Process. Through monitoring and evaluation the RD identifies important measures of change or patient/client outcomes relevant to the nutrition diagnosis and nutrition intervention and describes how best to measure these outcomes. The aim is to promote uniformity within the profession in evaluating the efficacy of nutrition interventions. In addition, an outcomes management system might be implemented.

Standard 4: Nutrition Monitoring and Evaluation		The "X" signifies the indicators for the level of practice		
		Generalist	Specialty	Advanced
(Bold Font Indicators are ADA Core RD Standards of Practice Indicators)				
<i>Each RD:</i>				
4.1	Monitors progress:	X	X	X
	4.1A Evaluates patient/client understanding and adherence with nutrition intervention	X	X	X
	4.1B Determines whether the intervention is being implemented according to prescription and/or identifies barriers to change	X	X	X
	4.1C Provides evidence that the nutrition intervention is or is not changing the patient/client behavior or health condition(s)	X	X	X
	4.1D Identifies positive or negative outcomes (eg, changes in HbA1c, blood pressure, lipids, weight)	X	X	X
	4.1E Obtains information to indicate progress or reasons for lack of progress	X	X	X
	4.1E1 Elicits feedback from patient/client about success with behavior change (eg, food and physical activity)	X	X	X
	4.1E2 Elicits feedback from patient/client about success/challenges with behavior change (eg, monitoring, taking medications, problem solving, healthy coping, reducing risk)		X	X
	4.1E3 Adjusts plan with patient/client to overcome obstacles to change	X	X	X
	4.1F Supports conclusions with evidence	X	X	X
4.2	Measures outcomes:	X	X	X
	4.2A Selects standardized nutrition care outcome indicator(s) to measure (eg, weight, HbA1c, lipids, blood pressure, food/activity records)	X	X	X
	4.2B Uses standardized nutrition care outcome indicator(s)	X	X	X

Figure 2. (Continued)

Standard 4: Nutrition Monitoring and Evaluation		The "X" signifies the indicators for the level of practice		
(Bold Font Indicators are ADA Core RD Standards of Practice Indicators)		Generalist	Specialty	Advanced
<i>Each RD:</i>				
4.3	Evaluates outcomes:	X	X	X
	4.3A Compares monitoring data with nutrition prescription/goals or reference standard	X	X	X
	4.3B Evaluates impact of the sum of all interventions on overall patient/client health outcomes	X	X	X
	4.3C Completes a comprehensive analysis of the indicators for each identified problem area using specialty level clinical judgment skills		X	X
	4.3D Completes a detailed analysis and trending of the indicators to evaluate the complexity of problems and correlates one problem to another using advanced clinical judgment skills			X
4.4	Documents:	X	X	X
	4.4A Date and time	X	X	X
	4.4B Indicators measured, results, and the method for obtaining measurement (eg, HbA1c, lipids, weight)	X	X	X
	4.4C Criteria to which the indicator is compared (eg, nutrition prescription/goal or a reference standard)	X	X	X
	4.4D Factors facilitating or hampering progress	X	X	X
	4.4E Other positive or negative outcomes	X	X	X
	4.4F Future plans for nutrition care, nutrition monitoring, follow up, and referral or discharge	X	X	X

Examples of Outcomes for Standard 4: Nutrition Monitoring and Evaluation

- The patient/client/community outcome(s) directly relate to the nutrition diagnosis and the goals established in the intervention plan. Examples include but are not limited to:
 - Nutrition outcomes (eg, change in knowledge, behavior, food or nutrient intake)
 - Clinical and health status outcomes (eg, change in laboratory values, body weight, blood pressure, risk factors, signs and symptoms, clinical status, infections, complications)
 - Patient/client-centered outcomes (eg, quality of life, satisfaction, self-efficacy, self-management, functional ability)
 - Health care utilization and cost effectiveness outcomes (eg, change in medication, special procedures, planned/unplanned clinic visits, preventable hospital admissions, length of hospitalizations, prevented or delayed nursing home admissions)
- Documentation of nutrition monitoring and evaluation is:
 - Comprehensive
 - Specific
 - Accurate
 - Relevant
 - Timely
 - Dated and timed

Figure 2. (Continued)

Standard 1: Provision of Services
Registered dietitians (RDs) provide quality service based on customer expectations and needs.
Rationale: Quality service is provided, facilitated and promoted based on the RD's knowledge, experience and understanding of patient/client needs and expectations.

Indicators for Standard 1: Provision of Services (Bold Font Indicators are American Dietetic Association (ADA) Core RD Standards of Professional Performance Indicators)		The "X" signifies the indicators for the level of practice		
		Generalist	Specialty	Advanced
<i>Each RD:</i>				
1.1	Provides input and is active in the development of diabetes screening parameters	X	X	X
1.1A	Complies with standards of diabetes care based on evidence-based guidelines and recommendations	X	X	X
1.1B	Identifies diabetes screening tools	X	X	X
1.1C	Develops diabetes screening tools		X	X
1.1D	Serves as team leader, utilizing expert knowledge and critical thinking skills, to develop, implement, review, and revise, as applicable, the diabetes screening tool/process as needed			X
1.2	Reviews and participates in collecting data to test the efficiency and effectiveness of the diabetes screening process related to practice area (eg, clinical, public health, home health)	X	X	X
1.2A	Audits diabetes screening processes for efficiency and effectiveness		X	X
1.2B	Analyzes, documents and reports data from diabetes screening audits		X	X
1.2C	Revises (or adjusts) diabetes screening processes as indicated by results of data collection		X	X
1.3	Contributes to the development of a referral process to ensure that the public has an identifiable method of being linked to an RD who will ultimately provide services	X	X	X
1.3A	Receives referrals for services from and recommends referrals to other health care professionals	X	X	X
1.3B	Tracks data to evaluate the effectiveness of diabetes referral process and systems	X	X	X
1.3C	Evaluates referral process, utilizing expert knowledge and critical-thinking skills		X	X
1.3D	Serves as team leader to direct and manage referral processes and systems, using a quality-improvement process		X	X
1.4	Collaborates with patient/client to assess needs, background, and resources in order to set priorities, establish goals, and create individualized action plans	X	X	X
1.4A	Understands behavior change and counseling theories and is able to apply theories in practice where appropriate	X	X	X
1.4B	Demonstrates leadership in utilizing, evaluating and communicating success in using different theoretical frameworks for intervention (eg, health belief model; social cognitive theory/social learning theory; stages of change [Transtheoretical Theory]; Enabling/Access Enhancing [PRECEDE model]; Fishbein/Ajzen [theory of reasoned action])		X	X
1.4C	Establishes systematic process to identify, track, and update available resources for patients/clients		X	X
1.4D	Directs and manages systematic processes to identify, track, and monitor utilization of patient/client resources			X

Figure 3. American Dietetic Association Revised Standards of Professional Performance for Registered Dietitians (Generalist, Specialty, and Advanced) in Diabetes Care.

Indicators for Standard 1: Provision of Services		The "X" signifies the indicators for the level of practice		
(Bold Font Indicators are American Dietetic Association (ADA) Core RD Standards of Professional Performance Indicators)		Generalist	Specialty	Advanced
<i>Each RD:</i>				
1.5	Involves patients/clients and their families in decision-making when appropriate	X	X	X
1.5A	Designs diabetes medical nutrition therapy (MNT) plan according to the patient/client's needs, with consideration and input from caregivers and other health care providers when appropriate	X	X	X
1.5B	Guides and teaches patients/clients and their support network in health care decision-making and goal-setting to positively maximize interventions and outcome measures	X	X	X
1.6	Recognizes the influence that culture, health literacy and numeracy, and socioeconomic status have on health and illness experiences and identifies the patient/client's use of health care services	X	X	X
1.6A	Adapts practice to meet the needs of culturally-diverse (race, ethnicity, age) populations	X	X	X
1.6B	Connects patients/clients/families/support network with established resources and services within their specific ethnic/cultural community	X	X	X
1.6C	Searches for additional resources to positively influence diabetes nutrition outcomes within the patient/client's specific ethnic/cultural community, and collaborates as appropriate	X	X	X
1.7	Applies knowledge and principles of disease prevention and behavioral change appropriate for culturally-diverse populations	X	X	X
1.8	Collaborates and coordinates with other professionals as appropriate	X	X	X
1.8A	Works within the multidisciplinary team to provide education, services, and/or programs	X	X	X
1.8B	Documents and reports, in partnership with health care provider and care system, referral sources for treatment, care, services, and education	X	X	X
1.8C	Serves in consultant role for medical management of diabetes and comorbidities		X	X
1.8D	Plans and develops larger population-based and specialty-focused health promotion/prevention programs based on client needs, culture, evidence-based strategies, and available resources		X	X
1.8E	Plans, develops, and facilitates implementation of systems of diabetes nutrition care and services (eg, chronic care model)		X	X
1.9	Applies knowledge and skills to determine appropriate diabetes self-management care plans	X	X	X
1.9A	Applies general diabetes knowledge and skills	X	X	X
1.9B	Applies knowledge and skills at the specialty level (ie, functional working knowledge of specialty area demonstrated by an understanding and use of the general principles, theories, and practices pertinent to the diabetes specialty) to determine the most appropriate action plan		X	X
1.9C	Applies knowledge and skills at the advanced practice level (i.e., advanced and comprehensive knowledge of diabetes care demonstrated by a thorough understanding and use of advanced diabetes self-care management principles, theories, and practices pertinent to diabetes care) to determine the most appropriate action plan			X

Figure 3. (Continued)

Indicators for Standard 1: Provision of Services		The "X" signifies the indicators for the level of practice		
(Bold Font Indicators are American Dietetic Association (ADA) Core RD Standards of Professional Performance Indicators)		Generalist	Specialty	Advanced
<i>Each RD:</i>				
1.10	Implements quality practice by following policies, procedures, legislation, licensure, credentialing, competency, regulatory requirements, and practice guidelines	X	X	X
1.10A	Participates in collection and documentation of nationally standardized and consensus-based diabetes performance measures (eg, National Committee for Quality Assurance [NCQA], American Association of Clinical Endocrinologists [AACE], American Diabetes Association)	X	X	X
1.10B	Participates as a committee member in the development and updating of policies and procedures and evidence-based practice tools		X	X
1.10C	Develops implementation strategies for quality improvement tailored to the needs of the organization and their client populations (eg, identification/adaptation of evidence-based practice guidelines/protocols, skills training/reinforcement; organizational incentives and supports)		X	X
1.10D	Develops and manages diabetes education program in compliance with national standards for diabetes self-management education (DSME) and diabetes self-management training (DSMT) and American Diabetes Association Education Recognition Program and/or the American Association of Diabetes Educators (AADE) Diabetes Education Accreditation Program		X	X
1.10E	Develops diabetes specific community/prevention programs incorporating behavior change theory, self-concept, lifestyle functions, and systematic evaluation of learning		X	X
1.10F	Leads process of developing, monitoring, evaluating, and improving the use of DSME and DSMT protocols/guidelines/practice tools			X
1.11	Advocates for the provision of nutrition care as part of public policy for diabetes prevention and DSME/DSMT and MNT	X	X	X
1.11A	Participates in the process of patient/client diabetes advocacy activities (eg, community diabetes screenings, local American Diabetes Association and Juvenile Diabetes Research Foundation [JDRF] events, National Diabetes Education Program [NDEP])	X	X	X
1.11B	Advocates for health promotion at the policy level and promotes health-related public policy by participating in legislative and policy-making activities that influence health services and practices	X	X	X
1.11C	Assesses patient/client population for situations where diabetes advocacy is needed (eg, local, state and national diabetes coalitions or collaborations)		X	X
1.11D	Takes leadership role and initiates advocacy activities/issues; authors articles and delivers presentations on topic; networks with other interested parties		X	X
1.12	Maintains records/documentation of services provided	X	X	X
1.12A	Organizes records for retrospective data analysis and prepares reports (eg, American Diabetes Association Education Recognition Program or AADE Diabetes Education Accreditation Program)		X	X

Figure 3. (Continued)

Indicators for Standard 1: Provision of Services		The "X" signifies the indicators for the level of practice		
(Bold Font Indicators are American Dietetic Association (ADA) Core RD Standards of Professional Performance Indicators)		Generalist	Specialty	Advanced
<i>Each RD:</i>				
1.13	Develops diabetes care protocols and policies for diverse populations	X	X	X
1.13A	Utilizes evidence-based guidelines, best practices, and national and international guidelines in the delivery of diabetes nutrition services	X	X	X
1.13B	Develops diabetes nutrition programs, protocols, and policies based on evidence-based guidelines, best practices, trends, and national and international guidelines		X	X
1.13C	Participates in the development of institutional pharmacotherapy protocols for diabetes care			X
1.13D	Directs the development of diabetes nutrition programs, protocols, and policies based on evidence-based guidelines, best practices, trends, and national and international guidelines			X
1.14	Participates in food/formulary delivery systems in terms of the nutrition status, health and well-being of diabetes populations	X	X	X
1.14A	Collects data and offers feedback on current food/formula delivery systems in health care and community settings, (eg, inpatient and ambulatory care settings, nursing homes, senior centers, home delivery)	X	X	X
1.14B	Collaborates in the design, evaluation, and/or revision of food/formulary delivery systems in health care and community settings (eg, inpatient and ambulatory care settings, nursing homes, senior centers, home delivery)		X	X
1.14C	Initiates the design, evaluation, and/or revision of food/formulary delivery systems in health care and community settings (eg, inpatient and ambulatory care settings, nursing homes, senior centers, home delivery)			X
1.14D	Provides guidance regarding enteral, supplements/feedings, Total Parenteral Nutrition, in accordance with best practice for diabetes care (eg, ADA, American Society for Parenteral and Enteral Nutrition)		X	X

Examples of Outcomes for Standard 1: Provision of Services

- Patients/clients participates in establishing goals
- Patients/clients needs are met
- Patients/clients are satisfied with services and products
- Evaluations reflect expected outcomes
- Effective screening and referral services are established
- Patients/clients have access to food assistance
- Patients/clients have access to nutrition services

Figure 3. (Continued)

Standard 2: Application of Research
RDs apply, participate in, or generate research to enhance practice.
Rationale: Application, participation, and generation of research promotes improved safety and quality of dietetic practice and services.

Indicators for Standard 2: Application of Research (Bold Font Indicators are ADA Core RD Standards of Professional Performance Indicators)		The "X" signifies the indicators for the level of practice		
		Generalist	Specialty	Advanced
<i>Each RD:</i>				
2.1	Reviews best available research findings for application to practice of diabetes care	X	X	X
	2.1A Demonstrates understanding of research design and methodology		X	X
	2.1B Demonstrates understanding of study outcomes and how to interpret and apply results to clinical practice		X	X
	2.1C Identifies key clinical and management questions and utilizes systematic methods to extract evidence-based research to answer questions			X
	2.1D Encourages the use of evidence-based tools as a basis for stimulating awareness and integration of current evidence		X	X
	2.1E Functions as an author/co-author or co-investigator of research and organizational position papers		X	X
	2.1F Functions as a primary or senior author or principal investigator of research and organizational position papers			X
2.2	Bases practice on sound scientific principles, best available research, and theory, and/or expert consensus	X	X	X
	2.2A Demonstrates adherence to evidence-based practice and considers the best available research on nutrition related prevention and treatment of diabetes to promote consistency in practice	X	X	X
	2.2B Systematically reviews the available scientific literature in situations where evidence-based practice guidelines for diabetes nutritional care do not exist		X	X
	2.2C Critically evaluates the best available research reflecting complex disease processes, and efficiently applies this research to clinical practice		X	X
	2.2D Participates in the development of evidence-based guidelines for use in diabetes clinical practice			X
2.3	Integrates best available research with clinical/managerial expertise and client values (evidence-based practice)	X	X	X
2.4	Promotes research through alliances and collaboration with other dietetics professionals and organizations	X	X	X
	2.4A Facilitates or participates in studies related to diabetes care	X	X	X
	2.4B Identifies research issues/questions		X	X
	2.4C Designs and leads studies related to diabetes care			X
	2.4D Collaborates with multidisciplinary and/or inter-organizational team to perform and disseminate diabetes research			X
	2.4E Leads multidisciplinary and/or inter-organizational research activities efforts, related to diabetes care			X

Figure 3. (Continued)

Indicators for Standard 2: Application of Research		The "X" signifies the indicators for the level of practice		
(Bold Font Indicators are ADA Core RD Standards of Professional Performance Indicators)		Generalist	Specialty	Advanced
<i>Each RD:</i>				
2.5	Contributes to the development of new knowledge and research in dietetics	X	X	X
2.5A	Participates in practice based research networks (ie, ADA's Dietetics Practice Based Research Network [DPBRN]; ADA's Evidence Analysis Library)		X	X
2.5B	Identifies and initiates research relevant to diabetes practice as the principal or co-investigator or as a collaborator with other members of the health care team or community			X
2.5C	Serves as a principal or co-investigator in collaborative research teams that examine relationships related to nutrition and diabetes care			X
2.6	Collects measurable data and documents outcomes within practice setting	X	X	X
2.6A	Develops and/or utilizes systematic processes to collect and analyze diabetes related data		X	X
2.6B	Monitors and evaluates pooled/aggregate data against expected outcomes		X	X
2.6C	Utilizes collected data as part of a quality improvement process to improve diabetes outcomes and quality of care		X	X
2.6D	Directs integration of diabetes research data into publications and presentations			X
2.7	Communicates research data and activities through publications and presentations	X	X	X
2.7A	Presents information on evidence-based diabetes guidelines and research at the local level (eg, community groups, colleagues)	X	X	X
2.7B	Presents at local and regional professional or consumer meetings		X	X
2.7C	Serves in leadership role for program planning of local, state, and regional meetings and for diabetes-related publications		X	X
2.7D	Presents at national and international professional or consumer meetings and serves as lead author on diabetes-related research in peer-reviewed publications			X
2.7E	Serves in a leadership role for program planning of national and international research oriented meetings and related publications			X

Examples of Outcomes for Standard 2: Application of Research

- Patient/client receives appropriate services based on the effective application of best evidence
- A foundation for performance measurement and improvement is established
- Best evidence is used for the development and revision of resources used in practice
- Benchmarking and knowledge of best practices is used to evaluate and improve performance

Figure 3. (Continued)

Standard 3: Communication and Application of Knowledge
RDs effectively apply knowledge and communicate with others.
Rationale: RDs work with and through others to achieve common goals by effective sharing and application of their unique knowledge and skills in food, human nutrition, and management services.

Standard 3: Communication and Application of Knowledge		The “X” signifies the indicators for the level of practice		
		Generalist	Specialty	Advanced
(Bold Font Indicators are ADA Core RD Standards of Professional Performance Indicators)				
<i>Each RD:</i>				
3.1	Exhibits knowledge related to diabetes care and education	X	X	X
3.1A	Reviews diabetes care and education publications and applies current knowledge to practice	X	X	X
3.1B	Interprets public health trends (eg, prevalence, prevention, and treatment) and epidemiological data and applies to professional practice/organization		X	X
3.1C	Interprets regulatory, accreditation, and reimbursement programs and standards for institutions and providers that are specific to diabetes care and education (eg, Centers for Medicare & Medicaid Services [CMS], The Joint Commission, NCQA, American Diabetes Association)		X	X
3.1D	Contributes to the body of knowledge for the profession (eg, research, presentation, publication)		X	X
3.1E	Acts as an expert reference for other health care providers, the community, and outside agencies related to diabetes care			X
3.2	Communicates sound scientific principles, research, and theoretical concepts	X	X	X
3.2A	Demonstrates critical thinking, reflection, and problem-solving skills at the specialty level (eg, selects appropriate information and best method or format for presenting it in writing or verbally) when communicating information		X	X
3.2B	Demonstrates critical thinking, reflection, and problem-solving skills at the advanced level (eg, able to convey more than mere procedural understanding) when communicating information			X
3.3	Selects appropriate information and best method or format for presenting in writing or verbally when communicating information	X	X	X
3.4	Integrates knowledge of food, nutrition, and metabolism with knowledge of health, social sciences, communication, and management theory	X	X	X
3.5	Shares knowledge and information with patients/clients, colleagues, and the public	X	X	X
3.5A	Authors articles for consumers and other health care providers	X	X	X
3.5B	Participates as an invited reviewer, author, and presenter at local, regional, and national meetings and media outlets		X	X
3.5C	Serves in leadership role for local and national organizations, as well as for publications (ie, editor, editorial advisory board) and on program planning committees		X	X
3.5D	Serves as national and international diabetes media spokesperson			X
3.5E	Functions as a key opinion leader/serves as consultant to business, industry, and national diabetes organizations regarding continuing education needs of consumers and health care professionals			X

Figure 3. (Continued)

Standard 3: Communication and Application of Knowledge		The "X" signifies the indicators for the level of practice		
(Bold Font Indicators are ADA Core RD Standards of Professional Performance Indicators)		Generalist	Specialty	Advanced
<i>Each RD:</i>				
3.6	Guides students, interns, peers, and others in the application of knowledge and skills	X	X	X
3.6A	Contributes to the educational and professional development of RDs, students, and health care professionals in other fields, through formal and informal teaching activities, preceptorship, and mentorship		X	X
3.6B	Fulfills teaching or faculty role for education programs for physicians and other health care professionals in pursuit of nutrition-related fellowships, training, and/or certification			X
3.7	Seeks current and relevant information to provide effective services	X	X	X
3.7A	Participates in, utilizes, and/or leads electronic professional networking groups to stay current in diabetes nutrition practice (eg, ADA's Diabetes Care and Education [DCE] DPG listserv, My AADE Network)	X	X	X
3.7B	Applies research for the development of diabetes protocols and/or guidelines for clinical practice and/or the organization		X	X
3.7C	Negotiates and/or establishes privileges at systems level for new advances in practice			X
3.8	Contributes to the development and dissemination of new knowledge	X	X	X
3.8A	Initiates and/or serves on planning committees/task forces to develop continuing education programs	X	X	X
3.8B	Uses clinical exemplars to generate new knowledge and develop new guidelines, programs, and policies in the advanced diabetes practice area			X
3.8C	Promotes dissemination of information about the evolving roles of the advanced level practitioner (eg, initiating/titrating medications based on provider-approved protocols)			X
3.9	Uses information technology to communicate, manage knowledge, and support decision-making	X	X	X
3.9A	Utilizes and/or participates in the development/revision of electronic health records	X	X	X
3.9B	Identifies and/or develops Web-based diabetes nutrition tools/resources		X	X
3.9C	Seeks opportunities to contribute expertise to national bioinformatics/medical informatics projects as applicable/requested			X
3.10	Contributes to the multidisciplinary approach by promoting strategies that impact health and quality-of-life outcomes of target populations	X	X	X
3.10A	Consults with health care providers and others (eg, public health officials or agencies, home health providers, case managers, community health workers, and school personnel) on clinical and other health-related issues	X	X	X
3.11	Serves as the diabetes nutrition expert within the multidisciplinary health care or management team	X	X	X
3.11A	Educates members of multidisciplinary teams in the clinical or community setting regarding the specialized knowledge and demonstrated skills of the specialty and advanced level practitioner		X	X

Examples of Outcomes for Standard 3: Communication and Application of Knowledge

- Expertise in food, nutrition and management is shared
- Individuals and groups:
 - Receive current and appropriate information
 - Understand information received
 - Know how to obtain additional guidance

Figure 3. (Continued)

Standard 4: Utilization and Management of Resources
RDs use resources effectively and efficiently.
Rationale: Mindful management of time, money, facilities, staff, and other resources demonstrates organizational citizenship.

Standard 4: Utilization and Management of Resources (Bold Font Indicators are ADA Core RD Standards of Professional Performance Indicators)		The "X" signifies the indicators for the level of practice		
		Generalist	Specialty	Advanced
<i>Each RD:</i>				
4.1	Uses a systematic approach to maintain and manage professional resources	X	X	X
4.2	Manages resources (eg, personnel, monies, equipment, and time)	X	X	X
4.2A	Participates in operational planning of diabetes programs (ie, staffing, marketing, budgeting, billing, program planning)	X	X	X
4.2B	Coordinates efficient delivery of diabetes and other related programs, including marketing, billing, coding, and revenue generation and reimbursement trends		X	X
4.2C	Designs and evaluates marketing strategies for RD services; collects and utilizes benchmarking data for staffing resources		X	X
4.2D	Leads in business and strategic planning at the institutional diabetes program level			X
4.3	Participates in analyzing safety, effectiveness, and cost in planning and delivering services and products	X	X	X
4.3A	Demonstrates understanding of and complies with the Joint Commission standards (www.jointcommission.org), the National Standards for DSME and the American Diabetes Association Standards of Medical Care, and those of other accreditation bodies	X	X	X
4.3B	Participates in the evaluation, selection, and implementation (if applicable), of new products and equipment to assure safe, optimal, and cost-effective delivery of diabetes nutrition therapy at the systems level		X	X
4.3C	Advocates for staffing that supports client population and census		X	X
4.3D	Designs, promotes and seeks executive commitment to a new service that will meet corporate or institutional goals for diabetes care (eg, provider-approved protocols to initiate/titrate medications)		X	X
4.3E	Analyzes, at the systems level, safety, effectiveness, planning costs, and delivery of services and products		X	X
4.3F	Leads development of relevant programs, services, and products			X

Figure 3. (Continued)

Standard 4: Utilization and Management of Resources		The "X" signifies the indicators for the level of practice		
(Bold Font Indicators are ADA Core RD Standards of Professional Performance Indicators)		Generalist	Specialty	Advanced
<i>Each RD:</i>				
4.4	Participates in continuous quality improvement and documents outcomes relative to resource management and/or delivery of services	X	X	X
4.4A	Proactively and systematically recognizes needs, anticipates outcomes and consequences of various approaches and modifies resource management and/or delivery of services as necessary to achieve desired outcomes		X	X
4.4B	Uses appropriate data collection tools to collect, document, analyze, and share outcomes data		X	X
4.4C	Leads the development, testing, implementation, and evaluation of new tools, as applicable			X
4.5	Advises patients/clients and others on appropriate and available resources and services	X	X	X
4.5A	Identifies, directs, and guides consumers to appropriate diabetes nutrition information	X	X	X
4.5B	Participates in programs that deliver cost effective treatment with improved metabolic outcomes (eg, diabetes prevention, reduction of diabetes complications, and improved quality of life)	X	X	X
4.5C	Provides guidance to consumers regarding participation in diabetes-related clinical research studies		X	X
4.5D	Exercises leadership to achieve desired outcomes using influence gained through advanced competence to identify and secure appropriate and available resources and services			X
4.6	Actively promotes the inclusion of DSME/DSMT and MNT service components in local, regional, and/or national diabetes data registries	X	X	X
4.6A	Assures that data on RD service providers are captured in databases	X	X	X
4.6B	Analyzes and utilizes information for long-range strategic planning (eg, program and service efficacy)		X	X

Examples of Outcomes for Standard 4: Utilization and Management of Resources

- Documentation of resource use is consistent with plan
- Data are used to promote and validate services
- Desired outcomes are achieved and documented
- Resources are effectively and efficiently managed

Figure 3. (Continued)

Standard 5: Quality in Practice
RDs systematically evaluate the quality of services and improve practice based on evaluation results.
Rationale: Quality practice requires regular performance evaluation and continuous improvement.

Indicators for Standard 5: Quality in Practice (Bold Font Indicators are ADA Core RD Standards of Professional Performance Indicators)		The "X" signifies the indicators for the level of practice		
		Generalist	Specialty	Advanced
<i>Each RD:</i>				
5.1	Complies with federal, state and local laws and regulations (eg, CMS, Health Insurance Portability Accountability Act [HIPAA])	X	X	X
5.1A	Interacts and serves as a resource with legislators, payers, and policy makers to contribute and influence diabetes care		X	X
5.1B	Leads advocacy efforts/initiatives for policy/legislation to benefit population with diabetes or at risk for diabetes across the continuum			X
5.2	Applies national quality and safety initiatives to practice (eg, The Institute of Medicine, Healthy People 2020, Healthcare Effectiveness Data and Information Set [HEDIS], NCQA, AACE, American Diabetes Association)	X	X	X
5.2A	Participates in hospital/agency/institution, and local, state, and national quality initiatives	X	X	X
5.2B	Leads efforts to maximize quality diabetes care		X	X
5.3	Participates in implementation of an outcomes management system to evaluate the effectiveness and efficiency of diabetes practice	X	X	X
5.3A	Selects criteria for data collection, and advocates for and participates in the development of clinical, operational, and financial data collection tools upon which diabetes nutrition care-sensitive outcomes can be derived, reported, and used for improvement		X	X
5.3B	Serves in leadership role to evaluate benchmarks of diabetes care based on public health and population based indicators (eg, Healthy People 2020 Leading Health Indicators, HEDIS, and national diabetes quality improvement measure sets)			X
5.4	Measures quality of diabetes care in terms of process and outcomes	X	X	X
5.4A	Participates in the development and implementation of policies and procedures for providing services and monitoring clients receiving diabetes care	X	X	X
5.4B	Evaluates the provision of diabetes care, including staff: patient/client ratio, reimbursement data and customer satisfaction survey results		X	X
5.4C	Develops policies for data analysis according to program needs			X
5.5	Identifies performance improvement criteria to monitor effectiveness of services	X	X	X
5.5A	Participates in multidisciplinary efforts to improve diabetes care outcomes	X	X	X
5.5B	Serves in leadership role of multidisciplinary efforts to establish and improve diabetes care interventions and outcomes		X	X
5.5C	Publishes effectiveness outcomes on programs and services			X
5.6	Designs and tests interventions to improve processes and services	X	X	X
5.6A	Contributes to awareness of potential drug-nutrient and drug-herb/dietary supplement interactions and potential interactions between scheduled treatments and complimentary/alternative therapies	X	X	X
5.6B	Develops systems to problem-solve and prevent errors (eg, medication errors, sharps disposal, blood-borne pathogens and infection control, hyper- and hypoglycemia)		X	X

Figure 3. (Continued)

Indicators for Standard 5: Quality in Practice		The "X" signifies the indicators for the level of practice		
(Bold Font Indicators are ADA Core RD Standards of Professional Performance Indicators)		Generalist	Specialty	Advanced
<i>Each RD:</i>				
5.7	Identifies and addresses potential errors and hazards in diabetes care	X	X	X
5.7A	Evaluates and ensures safe diabetes care		X	X
5.7B	Maintains awareness of problematic product names (eg, insulin products, oral diabetes medications, injectables) and error prevention recommendations provided by Institute for Safe Medication Practices (ISMP—www.ismp.org), Food and Drug Administration (FDA—www.fda.gov), and United States Pharmacopeia (USP—www.usp.org)		X	X
5.8	Identifies expected outcomes of diabetes care	X	X	X
5.8A	Participates in data collection and collation	X	X	X
5.8B	Identifies quality outcomes to measure (eg, American Diabetes Association, AACE, NCQA, institution-specific measures)		X	X
5.9	Documents outcomes of diabetes care	X	X	X
5.9A	Documents outcomes per selected protocol	X	X	X
5.9B	Documents and reports outcomes according to identified metrics		X	X
5.10	Compares actual performance to expected outcomes	X	X	X
5.10A	Compares individual performance to self-directed goals and expected outcomes	X	X	X
5.10B	Compares departmental/organizational performance to goals and expected outcomes		X	X
5.10C	Benchmarks departmental/organizational performance with national programs and standards		X	X
5.11	Documents actions taken when discrepancies exist between actual performance and expected outcomes	X	X	X
5.11A	Seeks opportunities to obtain knowledge and skills to improve performance	X	X	X
5.11B	Develops report of individual and departmental/organizational outcomes and improvement recommendations and disseminates findings		X	X
5.12	Continuously evaluates and refines diabetes care based on measured outcomes	X	X	X
5.12A	Utilizes a continuous quality improvement approach to measure performance against desired outcomes using data from multiple sources	X	X	X
5.12B	Leads in creating and evaluating systems, processes, and programs that support institutional and diabetes nutrition-related core values and evidence-based criteria		X	X

Examples of Outcomes for Standard 5: Quality in Practice

- Performance indicators are measured and evaluated
- Reports aggregate outcomes and compares to pre-established criteria (goals/objectives)
- Results of quality improvement activities direct refinement of practice

Figure 3. (Continued)

Standard 6: Competency and Accountability
RDs engage in lifelong learning.
Rationale: Competent and accountable practice includes continuous acquisition of knowledge and skill development.

Indicators for Standard 6: Competency and Accountability (Bold Font Indicators are ADA Core RD Standards of Professional Performance Indicators)		The "X" signifies the indicators for the level of practice		
		Generalist	Specialty	Advanced
<i>Each RD:</i>				
6.1	Conducts self-assessment of professional development opportunities at regular intervals	X	X	X
6.2	Identifies needs and seeks opportunities for professional development	X	X	X
6.3	Participates in peer review	X	X	X
6.3A	Participates in peer evaluation, including but not limited to peer supervision, clinical chart review, professional practice, and performance evaluations, as appropriate/applicable	X	X	X
6.4	Mentors others	X	X	X
6.4A	Participates in mentoring entry level and generalist RDs and dietetic interns	X	X	X
6.4B	Develops mentoring or internship opportunities for RDs in diabetes practice		X	X
6.4C	Functions as a preceptor for RDs and dietetic interns in diabetes care and management		X	X
6.4D	Functions as a preceptor for aspiring specialty level RDs		X	X
6.4E	Directs and guides the professional development of RDs through implementation of supervised practice experiences in diabetes care and mentoring programs		X	X
6.4F	Mentors RDs and other health care professionals in developing skills in accessing and critically analyzing research		X	X
6.5	Develops and implements a plan for professional growth	X	X	X
6.5A	Pursues opportunities to participate in diabetes continuing education programs locally, regionally, and nationally	X	X	X
6.5B	Develops and implements a plan for professional growth in the specialty practice areas of diabetes care (eg, participates in scholarly review of professional articles; serves as a reviewer or editorial board associate for diabetes journals)		X	X
6.5C	Develops and implements a plan for professional growth for advanced practice areas (eg, leading an editorial board for scholarly review, including but not limited to diabetes professional articles, chapters or books)			X
6.6	Documents professional development activities	X	X	X
6.7	Adheres to the ADA Code of Ethics	X	X	X

Figure 3. (Continued)

Indicators for Standard 6: Competency and Accountability		The "X" signifies the indicators for the level of practice		
(Bold Font Indicators are ADA Core RD Standards of Professional Performance Indicators)		Generalist	Specialty	Advanced
<i>Each RD:</i>				
6.8	Assumes accountability and responsibility for actions and behaviors	X	X	X
6.8A	Exemplifies excellence and exhibits professionalism in diabetes care (eg, manages change effectively; demonstrates assertiveness, listening and conflict resolution skills; demonstrates ability to build coalitions)	X	X	X
6.8B	Strives for an improvement in practice with self and others	X	X	X
	6.8B1 Is active in promoting the specialty of diabetes care		X	X
6.8C	Develops and directs policies and procedures that ensure staff accountability and responsibility when serving in a management role		X	X
6.8D	Leads by example; exemplifies professional integrity as a leader of diabetes care			X
6.9	Integrates the Revised SOP and SOPP for RDs in Diabetes Care into self-assessment and development plans	X	X	X
6.9A	Utilizes the Revised SOP and SOPP for RDs in Diabetes Care to assess performance at the appropriate level of practice	X	X	X
6.9B	Utilizes the Revised SOP and SOPP for RDs in Diabetes Care to develop and implement a professional development plan to enhance practice and performance	X	X	X
6.9C	Utilizes the Revised SOP and SOPP for RDs in Diabetes Care to develop and implement a professional development plan to progress practice and performance to a more advanced level		X	X
6.9D	Develops corporate/institutional policies, guidelines, human resource material (eg, job descriptions, career ladders, acceptable performance level) using the Revised SOP and SOPP for RDs in Diabetes Care as guidelines		X	X
6.9E	Uses advanced practice experience and knowledge to define specific actions for levels of practice (generalist, specialty, advanced) within the Revised SOP and SOPP for RDs in Diabetes Care			X
6.10	Applies current research findings and best available evidence into practice	X	X	X
6.11	Obtains occupational certifications in accordance with federal, state, and local laws and regulations	X	X	X
6.11A	Attains and maintains state of residency and/or state of practice licensure/certification as appropriate to practice setting	X	X	X
6.11B	Obtains and maintains specialty certification in diabetes (eg, Certified Diabetes Educator [CDE] or Board Certified–Advanced Diabetes Management [BC-ADM])		X	X
6.11C	Develops programs, tools and resources in support of assisting RDs to obtain specialty certification in diabetes care		X	X
6.11D	Develops programs, tools and resources in support of assisting RDs to obtain advanced practice certification in diabetes care			X

Figure 3. (Continued)

Indicators for Standard 6: Competency and Accountability		The "X" signifies the indicators for the level of practice		
(Bold Font Indicators are ADA Core RD Standards of Professional Performance Indicators)		Generalist	Specialty	Advanced
<i>Each RD:</i>				
6.12	Pursues leadership opportunities	X	X	X
6.12A	Pursues opportunities to acquire professional skills to network, communicate, and gather information to promote understanding of diabetes care	X	X	X
6.12B	Serves on local diabetes planning committees/task forces/advisory boards for health professionals and industry	X	X	X
6.12C	Serves on regional and national diabetes planning committee task force/advisory boards for health professionals and industry		X	X
6.12D	Proactively seeks opportunities to integrate diabetes practices and programs at the local, regional, national, and international level		X	X
6.12E	Pursues leadership development opportunities to be identified as a recognized expert in diabetes care		X	X
6.12F	Identifies new opportunities for collaborative practice and opportunities to promote the role of the RD in diabetes care		X	X
6.12G	Develops, tests, implements, reviews, and revises, as appropriate, innovative approaches to complex diabetes practice issues			X

Examples of Outcomes for Standard 6: Competency and Accountability

- Self assessments are completed
- Development needs are identified
- Directed learning is demonstrated
- Practice reflects the ADA Code of Ethics
- Practice reflects the ADA Standards of Practice and Standards of Professional Performance
- Practice reflects best available evidence
- Relevant certifications are obtained
- Commission on Dietetic Registrations recertification requirements are met

Figure 3. (Continued)